Maternal and Child Health Services
Title V Block Grant

State Narrative for Tennessee

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications may be obtained from the Tennessee Department of Health, Maternal and Child Health Section, located at 425 5th Avenue, North, 5th Floor, Cordell Hull Building, Nashville, TN 37243.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

MCH continued its history of holding public meetings in collaboration with the WIC program regarding its role and services offered at the county level. A letter announcing the location and time of the public hearings and fact sheet about both programs were sent to over 2500 people in different agencies and health care providers, and all physician members of the Tennessee Medical Association and the Tennessee Hospital Association. The information was released to the press, and was placed on the Department's web site. Three public hearings were held in June 2009, in Clarksville, Sullivan County and Memphis (Shelby County) representing the three grand divisions of the State.

Participants at the public hearings expressed an interest in receiving additional educational and promotional material regarding HUGS, Back-To-Sleep, Pregnancy Prevention, WIC, and infants with special feeding needs. Participants also voiced concern about the lack of transportation in rural areas where public transportation does not exist and individuals have a difficult time keeping clinic appointments. Participants asked for additional information regarding health prevention services. During the hearing held in Memphis, a participant provided a resource to the State for breast and cervical screening, diagnosis and treatment for under served and uninsured women in several of the West Tennessee Counties.

All concerns and findings from the hearings will be addressed, and feedback provided to the participants.

An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Budget shortfalls, a voluntary buy out program with a concurrent hiring freeze, and travel restrictions created a challenging year for Tennessee. The State's unemployment rate rose steadily, more than doubling since this time last year to 11%, although rates of up to 25% are not uncommon in more rural Tennessee counties. This has resulted in increasing needs for both traditional public health/MCH programs (e.g., an increase of about 20,000 WIC participants per month over the past 18 months) and for primary care services in the 53 local health department sites with primary care clinics. Counties with textile and auto manufacturing plants and their suppliers have been particularly hard hit with closures and subsequent loss of worker benefits.

Tennessee has no State income tax and is budget-dependent upon sales tax revenues which have been grossly under predictions for the past year. State-funded programs and positions have been reduced or eliminated (e.g., staffing levels were abruptly reduced by 5% during the buy-out). Further, Tennessee State law requires a balanced budget, and while many programs have been temporarily funded with State reserves and American Recovery and Reinvestment Act funds for the current year, this is not a sustainable plan. Additional budget shortfalls are expected, as are additional program and staffing reductions for next year. At risk for reduction or elimination:

- Perinatal Regionalization
- Child Health and Development home visiting (CHAD)
- Fetal Infant Mortality Review (FIMR)
- Infant Mortality reduction programs funded by TennCare and the Governor's Office of Children's Care Coordination
- Breast and Cervical Cancer

Our ability to meet match requirements for various programs supported by federal grants is of particular concern. For example, in addition to our $3 to $4 State/Federal match requirement for the MCH block grant, the Breast and Cervical cancer program requires a $1 to $1 match.

Despite these challenges, a number of accomplishments were logged:

- Significant decreases were observed in tobacco use (24.3% to 23.1%), diabetes prevalence (11.9 to 10.3) and youth suicide (10.3 to 6.9). More than 500,000 patients were screened for tobacco use, accessed free or reduced-cost counseling and tobacco cessation therapies and Quitline support. Community-based tobacco and diabetes prevention programs were funded across the state.
- In addition to direct links between tobacco cessation and diabetes prevention activities, a number of State-funded infant mortality reduction initiatives were launched. Preliminary findings from the Centering Pregnancy program are particularly promising with regard to improving gestational age and birth weight among high risk mothers and their babies.
- Basic education programs focusing on early childhood education were maintained and Tennessee was recognized for consistent improvements in high school graduation rates.
- A unique home visiting data collection project was developed and launched, yielding profile data from more than 2,000 families.
- The preventive dental program for children was recently recognized by AMCHP as a promising best practice.
- The Gold Sneaker program for fostering healthy behaviors among child care providers and children and their families was recognized by the National Governors' Association as an innovative best practice.
- Dr. Donna Petersen and Sally Fogerty provided technical assistance related to efficient organization, needs assessment, and child death prevention.

In light of continued budget challenges, goals for the coming year include: 1) maintaining current services and programs as we are able, 2) maintaining diabetes and tobacco prevalence reduction gains, and 3) improving data mining and epidemiologic capacity.

The Department of Health remains the single largest provider of care in Tennessee, serving about 1 million unduplicated patients per year.

Changes in population strengths and needs: As with much of the rest of the country, Tennessee is experiencing a deteriorating economic situation, an increasing unemployment rate, and rising costs of goods and services. These circumstances are contributing to an increase in the number of uninsured adults and an increase in requests for services from health department clinics.

Changes in State MCH program or system capacity: As a direct result of the budgetary situation in the State, the Governor announced a buy-out of selected state positions in the fall 2008. The Maternal and Child Health and Women's Health Genetics sections lost four positions in the central office -- one information systems, two clerical, and one program administrator. Local health department clinics in the rural regions lost 99 positions. The metro health departments also have been experiencing severe budgetary problems, and have lost positions. In addition, the State has been under a hiring freeze (except for nursing positions) for the entire year. The State also has been under an out-of-state travel freeze and the mandate to conduct most meetings by conference call. As a result, meetings and training events have been very limited. It is not expected that FY 2010 will change these restrictions.

New efforts have included the expansion of newborn hearing screening follow-up. July 1, 2008, a new law took effect requiring screening of all newborns prior to hospital discharge, reporting to the Department, and insurance coverage for screening. Improvements were also made to the Neometrics data system used by the State Lab and Follow-up staff for both metabolic and hearing screening.

With new funding from the Governor's Office of Children's Care Coordination, the Department is establishing fetal-infant mortality review teams in three metro counties (Shelby, Davidson, Hamilton) and in the rural counties of the East Tennessee Region.

Ongoing needs assessment activities: Annually, MCH staff review the birth, pregnancy, and death data when released by Health Statistics each fall. This information is available by county and by race. Special reports are also developed for program staff. Most are placed on the Department's web site and shared with field staff, advisory committees, and other partners working with MCH. Comparisons are made to the previous year, as well as charting indicators over time.

The Parent Subcommittee of the Newborn Hearing Screening Task Force has developed a Family Satisfaction Survey which is ready for distribution to families of children who are hard of hearing or deaf. Participation in the survey by families will be through the assistance of partner agencies (TEIS, CSS, Family Voices, and audiology centers). Surveys will be completed on Survey Monkey or returned anonymously in a prepaid envelope.

The Department completed the second year of data collection for PRAMS in May and just released internally a summary of findings from year one of the project.

5-year Needs Assessment activities: The Maternal and Child Health and Women's Health and Genetics sections are just beginning the process of developing the operational plans to conduct the 5-Year Needs Assessment. This year-long project will involve numerous partners from within and without the Department, as well as partners and health department staff across the state.

III. State Overview

A. Overview

While Tennessee has enjoyed some favorable economic trends in the past, February 2009 data show a 9.1 percent non-seasonally adjusted unemployment rate statewide as compared to 8.1 percent nationally. This trend is a major increase over last year's data for the state (5.5 percent). The state has a diverse market economy, a fairly large population of skilled laborers, low state taxes, and no personal income tax, which helps to attract business and industry. However, this has been superimposed on a background of dwindling federal aid, transference of jobs out of the country, the loss of manufacturing jobs and business revenue, high taxes on food, and increasing local taxes. The State continues to struggle with balancing its budget. Inner-city urban areas, small rural areas and unique areas such as those in the Appalachian Mountains continue to experience increasing poverty.

/2009/ The May 2008 data (2006 American Community Survey) show 4.6 percent non-seasonally adjusted unemployment rate statewide as compared to 4.14 percent nationally.// 2009//.

/2010/ The February 2009 unemployment data continue to highlight the severity of the deepening recession in Tennessee. The statewide unemployment rate remains on an upward trend and the number of unemployed persons has climbed to the highest since the state began keeping these records in 1973.//2010//.

Geography: Tennessee is a diverse state which covers 41,220 square miles of land area and is approximately 500 miles from east to west and 110 miles from north to south. The state is divided into 95 counties, each with a health department mandated by state law and located in the county seat. For departmental administrative purposes, the counties are grouped into seven rural and six metropolitan health regions.

Topographically, as well as culturally and economically, the state is divided into three grand regions. East Tennessee is a 35 county area, containing the Appalachian Mountains and bordered by Virginia, Kentucky, North Carolina, and Georgia. This region contains Knoxville and Chattanooga, the third and fourth largest cities, respectively. Johnson City, with a population over 50,000, is located in the extreme upper East end of the region and is the location of East Tennessee State University (ETSU) and the Quillen-Dishner School of Medicine. The ETSU Genetic Center provides on-going treatment and patient education after cases are confirmed by the Genetic Metabolic Centers. Erlanger Hospital in Chattanooga provides similar services after cases are confirmed. The University of Tennessee-Knoxville School of Medicine is one of the state's three Genetic Metabolic Centers, providing confirmatory diagnosis for suspected cases in the larger genetic region and treatment for those cases in the specific geographic area. These same medical sites also serve as the regional perinatal center sites. The East Tennessee region is home to ten nursing schools to help address the critical nursing shortage that faces our nation and public health infrastructure.

Middle Tennessee encompasses 39 counties and is bordered by Kentucky and Alabama. The topography ranges from mountains in the east to the Tennessee River on the western edge. Nashville, the capital of the state, and second largest city, as well as two other cities with populations over 50,000 are located in this region: Clarksville, home to the Fort Campbell military base; and Murfreesboro, one of the fastest growing cities in the state and home of Middle Tennessee State University. The Middle Tennessee region houses two of the country's oldest and most prestigious medical schools, Meharry Medical School and Vanderbilt School of Medicine; both provide program services. Meharry confirms all diagnoses of sickle cell anemia for suspected cases in the state and serves as the Middle Tennessee Regional Sickle Cell Center. Vanderbilt serves as the regional perinatal center and as another of the three Genetic Metabolic Centers confirming diagnoses for the larger region and providing treatment for cases in their specific catchment area. In addition, Vanderbilt houses one of the nation's noted Schools of Nursing which assists in developing the latest nursing curricula and produces top community program models. In addition, the middle region houses eleven more schools of nursing which assist in replenishing the retiring public health nursing infrastructure.

The western part of the state has 21 counties and is bordered by the Mississippi and Tennessee

Rivers and the states of Mississippi, Missouri, Kentucky and Arkansas. This area is part of the Delta, or Gulf Coastal Plain, and is very flat, rural and sparsely populated, with the exception of Memphis, the state's largest city, and Jackson. The University of Tennessee/Memphis Medical School is the third Genetic Metabolic Center confirming diagnoses for the West Tennessee area and providing treatment for cases in its catchment area through the Boling Center for Developmental Disabilities --an affiliate of the Medical School's Pediatric Department. This site also serves as the perinatal center for the western part of the state. Western Tennessee has ten nursing schools to address the growing infrastructure need.

Population Changes: Using the latest federal census figures, Tennessee's 2006 population was 6,038,636, which puts the state at 16th in the nation in total population. By 2010, Tennessee is projected to have a population of 6,264,654. During the 1990-95 period, Tennessee's population growth surpassed the increase experienced during the entire decade of the 1980's and outpaced the national average growth rate. During the 1990-99 period, Tennessee was the fourth fastest growing state in the Southeast. The distribution of Tennessee's population by race and sex has not changed significantly in the past several years: For people reporting only one race, 17 percent were black, 81 percent were white, less than 0.5 percent were American Indian and Alaska Native, less than 0.5 percent were Native Hawaiian and Other Pacific Islander, 1 percent were Asian, and 1 percent were some other races. Tennessee's population is 49 percent male and 51 percent female.

Tennessee is expected to gain 97,000 people through international migration between 1995 and 2025 and is expected to gain 845,000 people through internal migration for the same time period. The population over age 18 is expected to grow from 3.9 million to 5.2 million in 2025 while those classified as youth (under 20 years old) will decline from 27.7 percent in 1995 to 23.8 percent in 2025. The elderly population is expected to accelerate rapidly. All ethnic and racial groups are expected to increase during this time period except for non-Hispanic whites. African Americans, Asians, and persons of Hispanic origin will experience the greatest gain.

In 2005, 24 percent of Tennesseans were under the age of eighteen. Females aged 10-44 make up 24.7 percent of the total population. This reproductive age female population peaks within the 35-44 age group. The two largest population groups are reproductive age women and children under 18 --the target population served by MCH. This has implications for outreach and recruitment efforts as well as for types of services offered.

Continuing the trend established in the mid-1980s, Middle Tennessee counties led the state's recent growth, with an average increase of 16.5 percent between 1990 and 1998. East Tennessee counties were next, with 6.9 percent growth, followed by the West Tennessee counties, which experienced a 5 percent net increase. Metropolitan counties (defined as those within a Metropolitan Statistical Area [MSA]) grew an average of 11.5 percent between 1990 and 1998.

Slightly more than a quarter of all Tennesseans live in the four largest cities. Just over 68 percent of Tennessee's population resides in the state's seven MSAs, five of which are in the eastern two-thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee.

Ethnicity: Less than three percent of the people living in Tennessee in 2000 were foreign born, although the state has experienced a 169 percent increase from 1990. Of the foreign¬ born population, approximately 40 percent are of Latin American origin, and almost a third is of Asian origin. Hispanics are the largest ethnic minority in Tennessee. According to the 2000 Census, 123,838 persons, or 2.2 percent of all Tennesseans, identified themselves as being of Hispanic origin. In 2005, the Hispanic population is estimated at 3.0 percent, 172,704 persons. The actual number is most likely larger than the reported number due to the growing population of migrant workers and undocumented residents across the state.

Tennessee has a wide variety of ethnic groups in addition to Hispanics. Southeast Asians are the second largest group (72,031) and the state is the fifth largest Kurdish resettlement site in the country. Refugees and legal immigrants have also been arriving from African, Baltic, Central Asian, and Southeast Asian countries. Among people at least five years of age living in Tennessee in 2005, 6 percent spoke a language other than English at home. Of those, 55 percent spoke Spanish and 45 percent spoke some other language. According to the Tennessee Foreign Language Institute, there are over 169 different languages currently being spoken in

Tennessee.
Tennessee's immigrant and refugee population is concentrated in the Nashville area (50-60 percent), in Memphis (30 percent) and in the rural agricultural-based counties in the southeastern and western parts of the state.
These new arrivals face access to care issues: obtaining health insurance is a critical barrier to care. In addition, they may have chronic, difficult to treat health problems that are unfamiliar to health care providers. The language barrier is a very real obstacle to care, as is the mix of cultures with which providers are equally unfamiliar. The cultural factor has a special impact on maternal and child health service delivery. In addition, both the 2006 and 2007 legislative sessions had several pieces of legislation, although they failed to pass, which threatened to cut some of the basic services offered by any State agency for this growing population. These trends make it imperative for the Department to consider the health issues and implications of caring for this growing population.
Poverty Level: Tennessee figures from the 2005 American Community Survey Profile (U.S. Census Bureau) show 16.0 percent of Tennesseans live in poverty compared to 13.3 percent nationally. 21.4 percent of Tennesseans under age 18 live in poverty compared to 18.4 percent nationally. 12.5 percent of all families and 33.7 percent of families with a female head of household and no husband present had incomes below the poverty level. 10 percent of the population in Tennessee received food stamp benefits within the past 12 months compared to 6.7 percent nationally.
According to the 2008 Kids Count Data Book, in 2006, 23 percent of Tennessee's children under 18 were in poverty, compared to 18 percent for the United States. Tennessee ranked 41st in the nation on this measure, up from 34th in 2001. Eleven percent of children were in extreme poverty (below 50 percent poverty), compared to 8 percent for the nation. 8 percent of children were without health insurance, compared to 11 percent nationally. While overall poverty rates in the state and in the South have been falling, the condition of Tennessee's children is still a major cause for concern.
/2009/ In the 2007 KIDS COUNT Data Book, in 2005, 20 percent of Tennessee's children under 18 were impoverished, compared to 19 percent nationally. Tennessee retained its 36th rank. Ten percent of children remained in extreme poverty. Ten percent of children were without health insurance compared to 11 percent nationally.//2009//.
Income: Tennessee's median household income in 2004 was $38,874, which is 8.4 percent below that of the U.S. ($46,242). Tennessee's annual average rate has been below the national average since 1989 indicating that while most Tennesseans are employed, salaried and hourly employees make less on average than persons in other states. The 2005 national average per capita income was $25,035; Tennessee's for the same year was $22,090. Tennessee ranks 36th in the U.S. on this measure (University of Tennessee, Center for Business and Economic Research).
Households and Families: Of the total number of Tennessee households in 2005, 68 percent were families, mostly married-couple families. Thirteen percent were headed by single women. The recently added measure of grandparents as caregivers showed 134,157 (up from 113,247 in 2001) as having responsibility for their grandchildren under the age of 18. As in most other states, about half of the grandparents who live with their grandchildren are responsible for them. Of these grandparents, 19.2 percent live in poverty.
Health Statistics Data: As in the nation and in the other southeastern states, Tennessee rates for adolescent pregnancy have been on the decline. In 2003-04, Tennessee mirrored the nation by showing a slight rise in infant mortality. Memphis, the largest city in the state and located in the West Tennessee region, was recently noted to have the worst infant mortality rate in the nation for a major metropolitan area. In 2006, Tennessee was ranked 43rd compared to other states. Low birthweight (LBW), which is a major risk factor for adverse health outcomes for both infants and children, increased in recent years and was 8.2 percent in 2005. Between 1994-2004, LBW increased 7 percent compared to nation's 11 percent increase during the same period. Additionally, the African American low birthweight rate for 2005 was 15.3 percent, 1.9 times greater than the white LBW rate of 8.2 percent. This gap has been evident for many years and continues despite the increasing availability of services targeted to these populations. The LBW rate for Hispanic babies is 6.2 and did not significantly change between 1994-2004. Another

major concern is the disparity in the pregnancy outcomes for the African American and white populations. In 2005, the infant mortality rate for births to African American women in Tennessee was 2.7 times greater than the rate for births to white women. Data for 2003 for adolescent pregnancy (ages 10-17) show the lowest rate recorded since 1975. In 2005 this decreasing trend continued; the adolescent pregnancy rate for this age group was 13.3 percent. The rate dropped for both the white and the African American populations; however, the gap between the two groups remains. For 2005, the rate of adolescent pregnancy for the African American population was 2.3 times that for the white population. These data show that the MCH programs and services in Tennessee continue to be of great need and that resources must continue to be targeted to address the major disparities. In addition, the dismal rates show the need for more comprehensive data collection and analysis to assist in developing strategies to improve the pregnancy outcomes of the youngest Tennesseans.

Data trends on diseases: Disease trends for sexually transmitted diseases (STD) show that Tennessee has experienced a dramatic reduction in STD morbidity, with the exception of chlamydia, over the past five years. The rise in chlamydia morbidity has been due to additional screening within the family planning and STD clinics statewide. Like other STDs, syphilis is reported mostly from the large metropolitan areas. The six metropolitan counties represent approximately 42 percent of the State's population and reported 82 percent of the 779 cases of early syphilis cases in 2004. Nashville and Memphis reported 80 percent of the state's total cases. The 2004 data (1,159) show a significant decrease in cases since 2000.

The number of gonorrhea cases has declined from a record high rate of 817/100,000 in 1976 to 145.1/100,000 in 2004. This rate compares to 169/100,000 in 2002. The metropolitan counties have consistently accounted for 75-85 percent of the state's morbidity.

In 1995, state funding was made available for chlamydia testing in STD and Family Planning clinics. As a result, 13,152 cases were reported in 1995, a 94 percent increase over 1994. The overall statewide screening positivity rate for chlamydia increased from 7 percent in 2002 to 10.9 percent in 2004. 22,515 cases were reported in 2004. Of these cases, 72.1 percent occurred in females, reflecting the fact that most chlamydia tests are performed on women visiting health department STD, family planning and prenatal clinics. Black females aged 15-19 have the highest rate of infection. In 2004, 87 percent of chlamydia morbidity occurred among patients aged 15-29. Rural regions had positivity rates ranging from 5-11 percent, and the metropolitan areas ranged from 8-21 percent. Targeted services to decrease syphilis continue in Nashville and Memphis. Counties with the highest overall STD rates are in the western part of the state, which has a high percentage of minority residents. The Department continues to place significant emphasis on STD screening, outreach, and treatment, including chlamydia, gonorrhea, and syphilis, with clinic services available in all counties and targeted outreach in the larger metropolitan counties.

Health Disparity: The confounding issues of race and poverty contribute to some of the more serious health problems and health status indicators in the state. The following is a summary of significant issues the Tennessee Department of Health (TDH) is addressing through local health department services and state health initiatives focused on women, infants and children.

African-American adolescents have a disproportionately higher pregnancy rate than white adolescents in all age groups --a fact being addressed through the state's Adolescent Pregnancy Prevention Program, general health education, family planning clinics and EPSDT screenings offered through the local health departments.

A higher number of minority women are likely to enter prenatal care after the first trimester of pregnancy --which is being addressed through TennCare enrollment of pregnant women, home visiting services, public-private partnerships and pregnancy testing and referral available at all local health department sites. In addition, TennCare, Tennessee's Medicaid program has begun to utilize HEDIS quality measures to determine effectiveness of managed care organizations.

The infant mortality rate for minorities in 2005 was over two and one half times that of whites. African-American births comprise 20 percent of the total births, but 40 percent of all infant deaths were African-American. Neonatal mortality rates are 2.12 times higher for African American infants than they are for white infants (11.5 vs. 5.4). Local health departments are using the Help Us Grow Successfully (HUGS) home visiting program for special outreach and follow-up for high-risk pregnancies and high-risk neonates.

Currently the HUGS Program offers home visiting and care coordination services in all ninety-five

(95) Tennessee counties for pregnant women, postpartum women up to two years, women who have lost a child under the age of two years and children from birth through the age of five. A vital part of the program is the prevention and/or intervention services offered in the home setting because it provides an opportunity to gain greater understanding of the client's needs, constraints, and supports available in the home. Such services assist this population in gaining access to health care, psychosocial, educational, and other necessary services to promote good health practices, improve general well being, prevent developmental delays, and reduce maternal and/or infant morbidity and mortality. Home visitors have been cross-trained by WIC peer breastfeeding counselors to offer initial help to mothers during their first few weeks at home. In addition, efforts are being made to train home visitors to assess mothers for depression utilizing a standardized tool and to assist mothers in smoking cessation.
Because Sudden Infant Death Syndrome is the 3rd major cause of infant mortality in Tennessee, the state of Tennessee has created a program to help families reduce the risk of losing their babies to SIDS. The goal of the SIDS program is to reduce the number of SIDS deaths, and to provide bereavement support for families who have experienced the sudden, unexpected death of an infant. The program is designed to target several objectives focused on protecting Tennessee's infants from SIDS. One way to learn more about SIDS is to study information gathered from autopsies. The program is working to make autopsies available for every suspected SIDS death. Another objective is to maintain a system of collecting data that will help create a picture of the SIDS infant and family in Tennessee. A third objective is to provide support to families through published materials and home visits by public health professionals, as well as referrals for counseling, and support groups for families who have experienced the tragedy of SIDS. The Tennessee SIDS program is also dedicated to educating professionals, parents, community agencies, clergy, law enforcement personnel, emergency responders and all other interested persons who may encounter SIDS deaths throughout the state.
During the 2006 National Public Health Week, the Department of Health launched a statewide campaign to raise awareness of the State's horrific infant mortality rate. A logo and website were created. The logo has been utilized on several local media and public awareness projects that are presently being implemented.
High infant mortality rates are amplified in the western part of the state and include Memphis. The racial disparity is also worse in this geographic region. A summit of stakeholders representing community agencies, healthcare organizations and private providers, faith-based institutions, and the business entities was convened in Memphis in 2006. Governor Bredesen and the Shelby County local health department and government (location of Memphis) co-hosted the meeting. Governor Bredesen authorized the establishment of a statewide Fetal Infant Mortality Review, as well as a cabinet level coordination of statewide efforts to decrease infant mortality. Since 2006, he has authorized over 7 million dollars, a portion in recurring funds, to advance the efforts.
The local health department serves as a first point of contact for TennCare enrollment under presumptive eligibility for pregnant women. The Healthy Start Home Visiting Program targets first time, high-risk mothers with a special emphasis on teens who are parents. The Perinatal Regionalization system is an established, effective statewide service designed to provide expert consultation about problem pregnancies and to transport the mother and baby to the next level hospital when necessary to improve the health service available to the mother and/or infant. The Campaign for Healthier Babies in Memphis and West Tennessee continues as a strong population based approach, targeting women with media messages and coupon incentives promoting the importance of early prenatal care.
/2009/ Update on Infant Mortality efforts: The Governor's Office of Children Care Coordination (GOCCC) and the Department of Health continue leading efforts to decrease infant mortality in Tennessee. The GOCCC established three stakeholder advisory boards, one for each of the state's grand divisions. The GOCCC is directing the state's efforts to improve birth outcomes by issuing grants to implement evidence-based medical programs, social practices, and community organization which will establish priorities and sustain on going efforts that will lead to better preconception, prenatal and post-natal care of mothers and infants. Evidenced-based efforts funded and implemented across the state to achieve a reduction in the infant mortality rate are demonstrating success including: Centering Pregnancy, tobacco cessation in pregnant women, a youth messaging campaign and a home visiting program. Fetal Infant Mortality Review (FIMR)

was legislated and will be established in Chattanooga, Memphis, Nashville and rural East Tennessee. The first year of the CDC PRAMS survey data was completed April 30, 2008 and the State awaits analysis of the data.//2009//

/2010/ Update on Infant Mortality efforts: The Governor's Office of Children's Care Coordination (GOCCC) and the Department of Health continue leading efforts to decrease infant mortality in Tennessee. The GOCCC established three stakeholder advisory boards, one for each of the state's grand divisions. The GOCCC is a vital partner in efforts to improve birth outcomes. They have funded pilot grants aimed at improving preconception, prenatal, and post-natal care of mothers and infants. Evidenced-based efforts funded and implemented across the state to achieve a reduction in the infant mortality rate are demonstrating success including: Centering Pregnancy, tobacco cessation in pregnant women, a youth messaging campaign and a home visiting program. Fetal Infant Mortality Review (FIMR) was legislated and will be established in Chattanooga, Memphis, Nashville and rural East Tennessee. The first year of the CDC PRAMS survey data analysis is complete and the second year 2008 survey for birth mothers is currently approaching completion. There is a strong expectation that the 2008 survey will meet the 70% completion rate specified by the CDC. At this time, the project has also begun the implementation of the 2009 survey. The Tennessee PRAMS project within the Tennessee Department of Health is a CDC funded state-specific, population-based surveillance system designed to collect information on self-reported maternal behaviors and experiences that occur before, during and shortly after pregnancy.

Several programs aimed to reduce infant mortality sponsored by the GOCCC showed promising results. A Centering Pregnancy projected yielded 32 out of 36 infants born at normal weight and without perinatal complications. Tennessee Intervention for Pregnant Smokers (TIPS), a tobacco cessation program for pregnant mothers, preliminarily showed a significant reduction in prenatal and postnatal smoking and in August of 2008, the program further resulted in a 30% cessation rate. //2010//

The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. In 2006, Child Fatality Review Teams (CFRT) reviewed 1,088 (99.27 percent) of the 1,096 fatalities of Tennessee resident children under age 18 that occurred in 2006. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death). The manner of death for child fatalities in 2006 was determined by the CFRT to be: natural causes, 59.28 percent; unintentional injury (accidental) causes, 18.75 percent; homicide, 2.85 percent (down from 2.98 percent in 2005); suicide, 1.47 percent; could not determine, 5.51 percent; and undetermined due to suspicious circumstances, 7.72 percent.

The CRFT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death). The CFRTs' conclusions regarding the preventability are:

- 641 - Deaths were determined that they probably could not have been prevented
- 246 - Deaths were determined that they probably could have been prevented
- 95 - Preventability could not be determined
- 114 - Preventability is unknown

According to the 2006 Annual Child Fatality Report, there was a 36.51% decrease from 2005 in children whose cause of death was reported as SIDS. However the number of non-SIDS infants in an unsafe sleep environment increased 32.78% from 2005 to 2006.

African-American children, more than white children, are diagnosed with elevated blood lead levels. The Childhood Lead Poisoning Prevention Program's purpose is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often

changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN).
The local health department is an integral part of the health care delivery system. In rural and urban counties, the local health department provides many TennCare services as a means of ensuring access to care for eligible citizens. The local health department has always provided information and referral services for county residents. Local health department nurses have provided screening and then enrollment for pregnant women presumptively eligible for TennCare. In 1994, when the state's Medicaid managed care system (TennCare) was implemented, the Title V role changed once again but has not diminished in importance. Direct services in all traditional areas of public health are still provided and new roles developed, especially in relation to outreach and follow up with patients enrolled in TennCare. Title V service providers are flexible and responsive to the unique needs of county residents since the managed care system is so varied across the state. Public-private partnerships emerged to assure that health care needs are met.
In 2004, following a full year of study, the Governor proposed a comprehensive TennCare reform strategy designed to preserve full enrollment by placing reasonable limits on benefits. The plan garnered broad support from legislators, providers and enrollees, but public-interest lawyers thwarted it by refusing to lift legal roadblocks to reform.
As a result, in 2005 the State instead moved ahead with an alternate strategy to reduce benefits and enrollment for some adults while preserving full coverage for children. Even after reductions in adult enrollment to maintain fiscal balance, TennCare remains one of the most generous and comprehensive state healthcare plans. Moving forward, the State is pursuing a range of additional cost-containment strategies, including:
1) Requiring managed-care organizations (MCOs) to assume more financial risk in the delivery of TennCare benefits. The MCOs were relieved of financial risk in 2002 in an effort to stabilize the healthcare program. Restoring risk is critical to managing TennCare. 2) Increasing efforts to stamp out fraud and abuse. In 2004, Governor Bredesen launched the TennCare Office of the Inspector General to investigate civil and criminal fraud and abuse within the program. Since then, the State has opened investigations and brought charges against scores of individuals and organizations attempting to defraud taxpayers. 3) Working through the courts to challenge legal constraints. "Consent decrees" placed on the program by public-interest lawyers beginning in the 1990's obligate the State to provide benefits well beyond federal requirements and, among other things, prevent the State from placing reasonable limits on the use of prescription drugs. 4) Developing new care-and disease-management practices and making better use of health information technology (HIT). For example, the Governor's Volunteer Health Initiative is one of five federally funded HIT demonstration projects designed to lay out a national blueprint for improving the quality of health care while reducing costs in the healthcare system.
The State has reached a tentative agreement with TennCare enrollee attorneys and stakeholders that would preserve health coverage for approximately 97,000 "medically needy" enrollees --the sickest and neediest who generally do not qualify for Medicaid --in exchange for relief from certain legal constraints related to TennCare.
The proposed reform allowed TennCare to disenroll over 190,000 individuals including: 1) persons who were dually eligible on Medicare; 2) persons who are uninsurable but are eligible to transfer coverage under federal HIPAA rules; and 3) uninsured adults who could conceivably obtain insurance elsewhere. The disenrollment started June 2005. The proposed reform will limit pharmacy benefits and medical services for those adults remaining on the program. However, it does not affect the benefits of children or pregnant women.
In an effort to help the disenrolled population, Governor Bredesen appointed a "safety net" task force to make recommendations. The Governor's Task Force on the Healthcare Safety Net, the 26-member Task Force of healthcare professionals, state lawmakers, cabinet officials and local representatives, delivered its final report in May 2005 outlining 16 broad recommendations for strengthening safety net options in conjunction with reforms to TennCare. This "safety net" subsequently doubled the Department of Health's primary care clinic capacity and substantially expanded capacity in selected community clinics as well as in federally qualified health centers.
During the presentation of his 2006 State Budget, Governor Bredesen announced a series of initiatives to expand access to health insurance for uninsured Tennesseans, which he entitled

"Cover Tennessee". The targeted populations included broadening the SCHIP eligibility to include more children and subsidizing an affordable health insurance premium for employees of small businesses. In addition, the governor rolled out a plan to offer more preventative and improved treatment of the State's citizens with diabetes.
Cover Tennessee is an umbrella initiative with five targeted programs, including three health insurance products and pharmacy assistance: 1) CoverTN for employees of small businesses and self-employed individuals; 2) CoverKids for children and pregnant women; 3) AccessTN for individuals who are uninsurable due to their medical condition; and 4) CoverRx for stop-gap prescription drug help. All are currently accepting applications.
CoverTN is the centerpiece of this health care program. At its heart, CoverTN is a partnership between the state, individuals and small businesses. It offers affordable, portable and basic insurance coverage to those who have not been able to afford comprehensive coverage. The program pays for what is most important and cost-effective; and, it incorporates the concept of personal responsibility.
CoverKids offers comprehensive health insurance coverage to children 18 years-old and younger. Benefits are similar to those offered to dependents of state employees with emphasis on preventive care such as vaccinations, well-child visits and developmental screenings and maternity coverage for pregnant women.
CoverKids features no monthly premiums, but each participant will pay reduced co-payments for services. A family of four with a household income of $51,625 (250 percent of federal poverty level) or less is eligible. Families above the income limit may purchase coverage for their child by paying monthly premiums.
AccessTN was created for individuals with one of 55 specified medical conditions, or those who are unable to get insurance in the commercial market because of their health status. There is no income test for this program and premium assistance is available for low-income individuals.
CoverRx is designed to help those who have no pharmacy coverage, but have a critical need for medication. For many folks, access to prescription drugs for chronic conditions can mean the difference between debilitating illness and a productive life.
/2009/ Update on Cover TN Efforts: Throughout the 2007-08 year, the administration has sponsored "Call in events" statewide. In these events, Cover Tennessee representatives answer questions about CoverKids, CoverTN, CoverRx and AccessTN. The most recent event coincided with Cover the Uninsured Week 2008, April 27 to May 3, a national effort to highlight the fact that too many Americans live without health insurance. Callers ask questions about the programs, find out if they qualify, and to obtain assistance with the application process. Callers would have basic information available to enroll, such as Social Security numbers and income information for CoverKids, CoverRx and AccessTN, and federal employer identification numbers and Tennessee employer account numbers to enroll in CoverTN.//2009//
/2010/ Cover Tennessee provides health insurance coverage and pharmacy assistance to more than 93,000 Tennesseans through its four programs: CoverTN, CoverKids, AccessTN and CoverRx. Addressing the needs of the state's uninsured small businesses and employees, children and the medically uninsurable, these programs provide options and solutions where none previously existed.
Enrollment in the programs is promoted through community partnerships, a statewide faith-based initiative and a strong grassroots network of state and local organizations and leaders. In 2008, the programs of Cover Tennessee were represented at more than 350 community health fairs, events and gatherings. In addition, Cover Tennessee hosted approximately one dozen events across the state to provide information and enrollment opportunities to qualifying individuals and families.
More information about Cover Tennessee is available at www.CoverTN.gov or by calling 1-866-COVERTN. //2010//
Heart disease and stroke continue to be leading causes of death in Tennessee. Tennesseans also report a high prevalence of diabetes. In 2004, these three diseases resulted in premature deaths that translate to 124,283 years (almost doubled since 2002) of potential life lost for Tennesseans. A contributing factor to these diseases is obesity, and Tennessee ranks 8th worst in the nation for the percentage of adults who are obese. According to the results of the 2004 Behavioral Risk Factor Surveillance Survey and data collected by the Department of Health, an

estimated 34 percent of adults in Tennessee do not exercise at all. Six out of ten adults reported being either overweight or obese. Tennessee has the 4th highest smoking rate in the nation, with approximately 26 percent of adults being smokers. Seven out of ten people do not eat the recommended amount of fruits and vegetables. In 2002, more than 13,000 babies were born in Tennessee to mothers who smoked. Prenatal care was inadequate in 11.2 percent of live births in Tennessee in 2002.

Diabetes is also a leading cause of death and morbidity in the state. In 2006, the Governor launched "Project Diabetes" to help combat this killer. The initiative was subsequently housed in the Department of Health. The Community Services section helped implement the Tennessee Center for Diabetes Prevention and Health Improvement. The Center will make funds available to support implementation of innovative, evidence-based programs focused on the prevention and/or treatment of diabetes. The purpose of the Center is to develop and promote a statewide effort to combat the proliferation of Type 2 diabetes. As part of this effort, the Center intends to provide program implementation grants to providers of primary and specialty health care services related to the development of programs for prevention and treatment of pre-diabetes and diabetes.

/2009/ Update on Diabetes Prevention efforts: The Tennessee Center for Diabetes Prevention and Health Improvement awarded $342,000 in planning grants to seven organizations across the state. The funding will be used for efforts to prevent and treat patients with diabetes. The Project Diabetes planning grants will be used to fund a variety of education, treatment and prevention initiatives designed to reduce the burden of diabetes in Tennessee. //2009//

/2010/ Diabetes efforts in the state include the statewide initiative, Project Diabetes and the Diabetes Prevention and Control Program. Project Diabetes focuses on innovative education, prevention, and treatment programs for addressing diabetes and obesity. With 49 contracts in place throughout the state, the project serves both children and adults through preventative and treatment. Reaching over 150,000 Tennesseans, over $10 million in funding has been put into local communities since the program's inception. Diabetes Prevention and Control works to improve the system of care throughout the state through capacity building activities including the development of the State Plan for Diabetes and through training and technical assistance to health care professionals throughout all three grand divisions of the state. The program is federally funded through the Centers for Disease Control and Prevention.

Funding for local communities through the 49 Project Diabetes contracts include the following project goals:

- ***To decrease the prevalence of overweight/obesity across the State and, in turn, prevent or delay the onset of Type 2 diabetes and/or the consequences.***
- ***To educate the public about current and emerging health issues linked to diabetes and obesity.***
- ***To promote community, public-private partnerships to identify and solve regional health problems related to obesity and diabetes.***
- ***To advise and recommend policies and programs that support individual and community health improvement efforts.***
- ***To evaluate effectiveness of improvement efforts/programs that address overweight, obesity, pre-diabetes, and diabetes.***
- ***To disseminate best practices for diabetes prevention and health improvement for replication.***

Statewide initiative continues to focus on innovative education, prevention, and treatment programs for diabetes and obesity. //2010//

The Department of Health gained new leadership in Commissioner Susan Cooper in January 2007. The Commissioner brought a track record of developing and coordinating preventive health efforts.

Commissioner Cooper brought GetFitTN to the Department in 2007. GetFitTN is a statewide awareness program developed by Governor Phil Bredesen to address the rising epidemic of Type 2 diabetes and risk factors that lead to diabetes, like obesity. This initiative is aimed at educating both adults and children that Type 2 diabetes can be delayed or even prevented with modest lifestyle changes like increasing physical activity and a healthier diet. The Department of Health

has developed a website with resources including interactive tools for an individual to develop and implement personal health and wellness goals.
/2009/ In the fall of 2007, Commissioner Cooper led the Department's charge to decrease tobacco use in the 1 million Tennessee smokers. This massive effort had several parts and preceded the law to ban smoking in any enclosed establishment as well as parks, and sports venues if persons under the age of 18 years attended. The effort assisted in targeting teens, prenatal and postpartum women. It included: 1) evaluating all health department clients, 13 years or older, with a survey, and implementing the evidenced-based 5As or 5Rs approach; and 2) if client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment. This effort has met with fairly rapid success, significantly increasing the number of QuitLine users and persons agreeing to take smoking cessation medications. //2009//.
/2010/ The Department of Health was allocated state funding to continue a comprehensive Tobacco Use Prevention and Cessation initiative (TUPCP). The Department's implementation plan for this appropriation includes expanded cessation services offering counseling, nicotine replacement aids and medications to be offered in local health departments across the state. Clinical, medical and pharmacy protocols, provider training, dispensing of medications and data collection are included in the Department's plan of action. Local health departments are monitored according to data collection and clinical protocols with follow-up staff training and assistance.
The TUPCP launched a QuitLine web page which is accessible from the Tennessee Department of Health's website, http://health.state.tn.us/tobaccoquitline.htm and allows our regional staff, community projects, internal and external partners to freely print information on the services provided by the QuitLine, access promotional print materials and best practice strategies for offering services and treating tobacco use and dependency.
From August 2006 to December 2008, the Quitline has received a total of 24,707 calls. Seven thousand nine hundred and thirty (7,930) callers (32%) completed the Intake process and were assigned to a Quit Coach. Of the callers assigned to a Quit Coach, 5,627 callers (72%) have enrolled into the iCanQuit tobacco cessation program and 179 self-help information packets have been distributed.
TUPCP/TDH secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows, medical center journals, health system web reports, press releases, national, state and local news papers and health professional publications.
The TUPCP continued to receive great support from CDC, North American Quitline Consortium, Tobacco Free Tennessee, national, state and local advocacy partners, internal and external partners, the Governor, Commissioner of Health and Assistant Commissioner of the Bureau of Health Services Administration.
Collaboration and partnerships on policy efforts continue to grow with the state advocacy coalition-Campaign for a Healthy and Responsible Tennessee (CHART); primary partners-American Cancer Society, American Lung Association, American Heart Association, March of Dimes; and local coalitions-Smoke Free Nashville, Tobacco Free Memphis, Kingsport Tomorrow, and the Anti-Drug Coalition of Jackson County. As of 2008, there were a total of 1,880 members involved in state and local coalitions such as CHART, Smokefree Nashville, etc.
In February 2008, TUPCP with advocacy partners, CHART (Campaign for a Healthy and Responsible Tennessee), American Heart Association, American Lung Association, and the American Cancer Society participated in the first CDC sponsored state training on the development of a Sustainability Plan for state funding of tobacco control. This Plan serves as a framework for FY 08 and FY 09 strategies implemented by the state advocacy coalition -- CHART. In 2008, TUPCP contracted with the Tobacco Technical Assistance Consortium to facilitate a strategic planning process to develop a new state plan for 2009-2013. With the assistance of more than 40 state and local partners, representing tobacco regulation, enforcement, advocacy, health communication, community based programs, healthcare insurers, community health centers, etc. a draft state plan for tobacco use

prevention, control and cessation was created in November 2008. TUPCP anticipates finalizing the plan this year.
The TUPCP maintains an email list by which announcements are made, information shared and action alerts are forwarded to regional programs, community funded projects and strategic partners.
The Department of Health's program will continue to raise awareness of the dangers of tobacco use; mobilize the general public and priority populations; build capacity of state and local coalitions to effect tobacco related social norms, promote environmental change and support grass roots advocacy for tobacco-free policies. The program plans to strengthen its relationships with internal and external partners by convening quarterly meetings of the multiple strategic planning workgroups and maintaining monthly technical assistance and training teleconferences with regional staff and community program staff. //2010//

B. Agency Capacity

(Due to the small amount of characters left for this section for FY 09, we were unable to use required format without deleting sections. Thus the section has been updated throughout.)

The state has local health departments in all 95 counties that carry out health related programs for women, infants and children. Local health departments operate in collaboration with the county executive or mayor and county commissioners. Metropolitan counties have boards of health which set general policy for their health departments. Funding for local and metropolitan health departments comes from local, state and federal government sources, third party payers and client fees. Maternal and Child Health funds contribute to the financial base of all county health departments. Each county has one or more health department sites delivering health services, including family planning, child health, EPSDT, immunizations, home visiting services, care coordination for families with children with special health care needs, pregnancy testing, basic prenatal care, prevention and treatment of sexually transmitted diseases, WIC, and TennCare outreach and advocacy. Other services (primary care, prenatal care, tuberculosis and HIV/AIDS management, etc.) are provided at selected sites depending upon need and availability of resources. The Department (TDH) contracts with universities, hospitals and other community -- based, non-profit agencies for services such as perinatal regionalization services, genetics, children's special services, additional family planning sites, and child care technical support services. Primary care services are provided by 55 of the 95 county health departments designated as TennCare primary care providers and provide 24-hour coverage and referral (after hours needs are handled by telephone).

The Department contracts with the TennCare MCOs operating in the rural counties to provide TennCare covered services. Other health services can be provided to women, infants and children if individual authorization is approved. Staff are very involved in care coordination and case management to assure that women, infants and children enrolled in TennCare receive the services they need.

Description of Children's Special Services (CSS) Program:
Children's Special Services (CSS) is the state's Title V CYSHCNs program. Children's Special Services addresses the special health care needs of children from birth to the age of 21 years who meet both medical and financial criteria. State statue defines children with special health care needs as: "A child under the age of 21 who is deemed chronically handicapped by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."
Children Special Services has an established financial criterion of income not greater than 200%

of the federal poverty level. The program financial guidelines are updated by April 1 of each year. In order to assist families in qualifying financially, the CSS program will use spend-downs including; premiums paid to other health insurances, payments for child support, and any paid medical bills incurred over the past year for the entire family.
CSS provides reimbursement for medical care, supplies, pharmaceuticals, and therapies directly related to the child's diagnosis. Medical services are provided through a network of CSS and TennCare/Medicaid approved providers. Each family is required to apply for TennCare and assisted in finding a medical home as well as any needed specialists.

CSS contracts for various multidisciplinary medical clinics in university hospitals and other private provider offices. Comprehensive pediatric assessment clinics are not held in the regional and metro health departments due to primary care services being conducted through TennCare and its physician provider network. CSS holds numerous orthopedic clinics and craniofacial clinics throughout the state. Since most children have some form of health insurance, including TennCare, the program makes every effort to obtain reimbursement for medical services.

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available. Approximately forty-one percent or 2,378 of the 5,802 CSS enrollees have SSI.

CSS provides care coordination services to all its clients in all 95 counties. Care coordination services are provided by social workers and public health nurses and include assessments of both medical and non-medical needs, and serving as a liaison between the medical provider, insurance company, transportation services, and the family. CSS care coordinators may attend CSS clinics, private clinics, and multidisciplinary meetings in the educational setting.

Children's Special Services recognizes the need for parents of a recently diagnosed child to talk and meet with other parents of a similar or like diagnosed child, so those parents can impart their knowledge, understanding and experience. If a family cannot be referred to another parent of a similar or like diagnosis then the family is referred to the national Mothers Understanding Mothers (MUMS) organization. At present, CSS does not reimburse the $5.00 fee for using the MUMS service.

Description of preventive and primary care services for pregnant women, mothers and infants:
All local health departments provide pregnancy testing, counseling, and referral for prenatal care; HIV testing; WIC and nutrition services; presumptive eligibility for pregnant women for TennCare/Medicaid (pregnant women below 185% of the federal poverty level are eligible for TennCare); and testing for sexually transmitted diseases. To qualify for Presumptive Eligibility, four criteria must be met: Tennessee residence, valid social security number, household income at or below185 % federal poverty level, and verification of pregnancy. Staff assists with referrals to the Department of Human Services, which is responsible for TennCare enrollment. Staff also provide outreach and advocacy services for TennCare enrollees, including assistance in accessing medical care by identifying providers and setting up appointments, reminder phone calls, assisting the enrollee in understanding the TennCare system, assisting with appeals, and educating enrollees about the important concepts of a medical home, use of the primary care provider, and preventive health education. All regions have home visiting services for pregnant women and infants considered to be at risk and in need of such services.

The state's perinatal regionalization system consists of the five regional perinatal centers, making high-risk obstetrical and neonatal care accessible to all physicians and health care facilities statewide. This system provides a mechanism for consultation regarding high-risk pregnant women and infants and a system of referral and transfer, when necessary. The system also provides postgraduate education in perinatal medicine for health care providers. Access to the appropriate level of high-risk care is facilitated through the agreements among delivering

hospitals, physicians and the centers. The perinatal regionalization system has a 21-member Perinatal Advisory Committee staffed by Women's Health. During FY 2008, there were 14,144 deliveries at the five Regional Perinatal Centers, 4,300 NICU admissions, 1,305 newborn transports, 1,110 follow-up clinic visits, and 5,206 educational hours provided to health care providers. Staff at the Centers provided approximately 1,971 documented telephone consultations and 20,000 onsite patient consultations.

Family planning services are available in every county at 130 clinic sites (health departments, Planned Parenthood agencies, primary care sites). Services include counseling and education, exams, laboratory tests, and contraceptive supplies, and are available upon request to any reproductive age person. During CY 2008, the program provided services to 121,105 persons.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program provides nutritional counseling and education, supplemental foods and health care referrals to approximately 174,000 eligible participants. Participants are pregnant, post partum or breastfeeding women, infants and young children under five years of age who are at nutritional or medical risk of poor growth and development and who meet the required income guidelines. WIC services which include nutrition education, referrals and vouchers for food are provided at approximately 140 local health department, primary care, and hospital sites throughout the state. Nutritionists provide education and information to individuals or groups regarding nutrition and physical activity, and other healthy behaviors for everyday living. Registered dietitians counsel individuals with special dietary needs such as gestational diabetes, PKU, and food allergies. Breastfeeding promotion and support are also available statewide with some locations having breastfeeding peer counselors.

The State Genetics and Newborn Screening (NBS) Program requires by law that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases, including sickle cell. The NBS follow-up nurses are located at the State Laboratory to assure that all abnormal results are reported as quickly as possible. The program involves cooperation between birthing hospitals, the State Laboratory, the NBS Program staff, the Genetic Centers, Sickle Cell Centers, endocrinologists, Cystic Fibrosis Centers, and primary care physicians. The state is currently testing for 41diseases (which may reflect 57 different genetic disorders). For additional information, see NPM #1.
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Newborn Hearing Screening: The Newborn Hearing Screening Program is also known as Early Hearing Detection and Intervention (EHDI). A mandate, know as Claire's Law, was passed effective July 1, 2008 and requires all birthing hospitals to conduct newborn hearing screening prior to discharge or one month of age. In addition, insurance companies are required to cover the initial hearing screening, and audiologists and medical providers are required to report follow-up testing. In CY2008, 95% of 90,960 occurrent births (preliminary) received a hearing screen; of the 86,434 infants that received the hearing screen, 3,619 (3.6%) infants did not pass; and 1,447 (1.6%) of all infants screened were reported to have at least one risk factor for hearing loss. The percentage of infants completing follow-up after a failed initial screen increased from 66% (2007) to 67% (2008 preliminary). An additional 5% (194 infants) have pending hearing results from an audiologist. In CY2007, 51 infants were reported to have permanent hearing loss. Preliminary CY2008 data indicate 65 infants have been reported with hearing loss. See section on NPM #12 for information regarding meeting benchmarks.
Staffing changes during 2008 for the hearing program: Newborn Hearing Screening (NHS) is coordinated by 1 FTE public health nurse consultant located in Nashville and funded by the MCH Block Grant. There is .75 FTE support staff assigned to assist the NHS. The program lost a 1.0 FTE position for a support clerk in August. NHS contracts with the University of Tennessee Knoxville Center on Deafness for 0.75 FTE audiology consultant (an increase of .25 FTE). She is located in Knoxville, about 3 hours from Nashville. Parent support services are contracted through Family Voices for 1.0 FTE parent consultant (3 part-time parents) (an increase of .25 FTE). The parents are located in the East, Middle and West regions of the state. The program

collaborates with the Department of Education Early Intervention System (TEIS) for hearing follow-up activities by the TEIS services coordinators located in each of the 95 counties and has access to 0.5 FTE deaf educator for follow-up and training activities. The deaf educator is located in Knoxville and is housed at the Center on Deafness with the audiology consultant. In addition, the award of a CDC Early Hearing Detection and Intervention grant in July 2008 (see section on NPM #12) provided the program with 1 FTE epidemiologist for data systems and reports and 1 FTE nurse consultant (2 part-time nurses) to assist with follow-up activities. Newborn hearing screening is not provided in the local county health departments at this time. Infants requiring follow-up are referred to a network of over 80 pediatric audiology providers. A Directory of Pediatric Audiology Providers is available to medical providers and on the state's web site. The Newborn Hearing Screening Program has a Task Force comprised of 30 professionals and consumers and functions as a sub-committee for the State Genetics Advisory Committee and the Statewide Genetics Coordinating Committee.

Child Health:
The Child Health and Development (CHAD) home visiting program continues to be partially funded by the Tennessee Department of Children's Services. CHAD serves low income families considered to be at risk for abuse and neglect. Funding for this program provides services in 22 of the 95 Tennessee counties. Other counties are covered by other funding sources and implement slightly different home visiting models; all home visiting models include risk assessment and identification of intervention intensity (weekly, bi-weekly or monthly) and assurance that infants and children receive immunizations and EPSDT services. When other needs are identified, the child or family is referred for community services. The CHAD field staff are now being trained in the Florida home visiting curriculum and are also implementing the electronic data collection system instituted for other home visiting models so that consistent information and outcomes are collected on all children enrolled in the program. In FY 2008, CHAD served 916 families, which included services to 1,326 children. In FY 2009, 866 families with 1228 children received services through CHAD.

EPSDT: All 95 county health departments continue to provide EPSDT screenings to TennCare eligible children. In FY 2007/2008, 58,428 screenings were done by the health departments. The Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2007-08 from DCS show that over 93% of children had been screened. The TENNderCare Community Outreach program, the TENNderCare Call Center program and the TENNderCare Nursing Call Center raise awareness of the importance of EPSDT screening to parents of TennCare eligible children.

Early Childhood Comprehensive Systems (ECCS):
The TN Department of Health -- Maternal and Child Health Section serves as the organizing office for the state's Early Childhood Comprehensive Systems (ECCS) Program. More than 100 other programs or departments concerned with having children healthy and ready to learn upon school entry are actively involved in the partnership, which is built on the initial work of the Healthy Child Care America initiative.
Tennessee has more than 300,000 children under the age of six in out-of-home care each day. There are more than 8,400 children under the age of 19 in foster care. Of those, 1,850 are under the age of 5, an indicator of family instability that affects child well-being. In 2008, the US Census Bureau estimated that almost nine percent of Tennessee's children under age six, approximately 46,000 total, are uninsured and do not have access to health care. The need for strong, effective, coordinated services that assure quality health care and a medical home for all children is critically important. These services should address family support and parenting education, provide quality early care and education and foster social-emotional development to promote child development and school readiness.
The work of ECCS is accomplished through the continuous effort of the advisory committee, made up of representatives for each of the identified organizations concerned about early childhood well-being. To date, there are 130 participants listed in the ECCS directory with 60 active members. These individuals attend quarterly meetings and participate in monthly

conference calls for various subcommittees organized to accomplish ECCS objectives. The Director of ECCS is responsible for recruiting new members and supporting the work of the subcommittees to accomplish the goals of the ECCS Program. The executive committee of ECCS oversees the work of the partnership in relation to the goals, objectives and work plan developed cooperatively by all members. The program director, key departmental leaders and the chairs of each of the subcommittees make up the executive committee of ECCS.
The goal of ECCS is to assure that all children are healthy and ready to learn upon school entry.
The working objectives for FFY 2009 -- 2011 are to:
1. Continuously develop the effective relationship between partners by focusing on the state plan, defining the work and tracking the progress of ECCS.
2. By 2011, expand the partnership to include agencies concerned about the mental health needs of young children, including developmental assessment agencies.
3. By 2011, include at least 5 non-traditional partners that address issues related to children ages 0-5 years with special health care needs.
4. By 2011, recruit and involve families in the regional and local activities to support the work of the partnership and address regionally identified needs to assure that children are healthy and ready to learn upon school entry.

Child Care Resource and Referral Centers (CCR&R): There are more than 4,900 regulated child care providers with a capacity to serve more than 330,000 children. The staff of the 11 Resource and Referral Centers include child care specialists as well as specialists in other areas related to child care such as Infant & Toddler Specialists. Direct services rendered to child care providers included over 3,000 training sessions, on-site consultations, and use of regional lending libraries -- most related to the prevention of health and safety problems for the children served. Indirect services included community presentations, a quarterly newsletter, and a CCR&R website linked to the Department of Health's site. Parent referrals are routed over a toll-free phone number that is promoted locally in a colorful brochure. Community participation is noted by CCR&R involvement with several advisory boards including the Early Childhood Comprehensive Systems (ECCS) and the Tennessee Association for the Education of Young Children (TAEYC).

Adolescent Health: The Adolescent & Young Adult Health in Tennessee Report of 2006, an Executive Summary, and Fact Sheets were distributed to stakeholders including public health staff and community agencies. This information was made available on the Tennessee Department of Health, Adolescent and Young Adult Health Program website at http://health,state.tn.us/MCH/Adolescent/adolescent index.htm. A youth health guide, Your Health is in Your Hands, was distributed to over 75,000 young people through the community adolescent health coordinators school staff, the faith community, youth organizations, TENNderCare, and health fairs. Conference planning and underwriting was provided for the Yes2Kids Conference. The adolescent health director facilitates quarterly meetings of the Adolescent Health Coordinators, and the Adolescent Health Advisory Committee.

Tennessee Asthma Management Program: The Adolescent Health Director also manages the State Asthma Program. The mission of the State of Tennessee Asthma Taskforce (STAT) is to promote lung health and reduce asthma disease and disparities through agency and community collaborations, advocacy, and education. STAT's priority is to develop and implement a comprehensive state plan to reduce the burden of asthma among Tennessee's school children in consultation with the Department of Education and the Bureau of TennCare.

Child Fatality Review Team (CFRT): The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. During 2006, Child Fatality Review Teams (CFRT) completed a total 1,088 reviews. This represents 99.27 percent of all 1,096 child deaths of children age 17 and under for 2006. Department of Health team leaders provided administration and coordination of the regional teams. 2007 deaths have been reviewed; analysis is in process.

The CRFT reviewed the way children died (Manner of Death) in Tennessee and what caused the

deaths (Cause of Death). The CFRTs' conclusions regarding the preventability are:
• 641 - Deaths were determined that they probably could not have been prevented
• 246 - Deaths were determined that they probably could have been prevented
• 95 - Preventability could not be determined
• 114 - Preventability is unknown
According to the 2006 Annual Child Fatality Report, there was a 36.51% decrease from 2005 in children whose cause of death was reported as SIDS. However the number of non-SIDS infants in an unsafe sleep environment increased 32.78% from 2005 to 2006.

Sudden Infant Death Syndrome (SIDS): The SIDS program includes making autopsies available for every suspected SIDS and Sudden Unexplained Child death through the Autopsy Rule. Support to parents, their families and caregivers is provided through published materials, home visits by health care professionals, referrals for counseling and association with parent groups of those who have experienced a SIDS death.
A law mandating the Departments of Health and of Children's Services to train first responders (Emergency Medical Technicians, professional firefighters, and law enforcement officers) in conducting the Death Scene Investigation of the sudden unexplained death of a child has progressed. This training entitled "Prevention Through Understanding" must include information about SIDS and responding to a grieving family. In January 2009, a Death Scene Investigation In-service for Trainers was conducted in Memphis. Due to demand, the department has increased the frequency of the Death Scene Investigation Trainings to twice a fiscal year. A second class was conducted in April 2009, in Johnson City. The curriculum manuals and the in-service program have been approved for in-service and pre-service training by the Commission for Law Enforcement, the State Commission Board for Fire Fighters, and the Board of Licensure and Education for Emergency Medical Services. "Prevention Through Understanding" has been approved for five contact hours for trainers who go through the program and for two contact hours for trainees who attend a trainer in-service or pre-service program. Through the Death Scene Investigation Training, training has been provided, between February 2003 and June 2008, to a total of 13,083 persons -- 12,778 first responders and 305 first responder trainers. This includes training to 1,779 law enforcement officers, 6,402 professional fire fighters, and 4,902 emergency medical technicians. In addition, the program has reached another 257 people representing other state affiliations and members of child fatality review teams.

Childhood Lead Poisoning Prevention Program (CLPPP): The Childhood Lead Prevention Program Program's purpose is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.
Lead poisoning remains a preventable environmental health problem in the United States. One of the specific national goals within HHS's Healthy People 2010 initiative 8 -11 is the total elimination of BLLs > 10 ?g/dL in children age 1-5 years old. Analysis of national data has shown that although childhood lead poisoning occurred in all populations, the risk is higher for persons having low income, living in older housing, and belonging to certain racial and ethnic groups. For all income levels, non-Hispanic black children have a greater risk of elevated blood lead levels (EBLL) than white children; the disparity is even greater for black children living in families below the poverty level. Children enrolled in Medicaid have three times the prevalence of elevated blood lead levels compared to non-Medicaid children. Blood lead levels are highest among young children (less than six years old) since their smaller body weight results in greater exposure per pound. Children living in poverty are at higher risk of lead poisoning than other children and more than a quarter of the very young children in Tennessee live in poverty.
According to Tennessee vital statistics, the population of children aged 0-6 was estimated to be 556,545 in 2007 and 560,742 in 2008. From July 1, 2007 to June 30, 2008 a total of 73,803 children, ages six years and younger, were lead screened by a venous blood test. From these screenings, a total of 132 (0.18%) were confirmed to have elevated blood lead levels.

In collaboration with the Tennessee Lead Elimination Program (LEAP), located at Middle

Tennessee State University, as of February 2009, 71 referrals have been made to the LEAP program.

FIMR: The Fetal Infant Mortality Review in Tennessee was established by legislation in 2006, and is being piloted in three urban locations across the state and one rural location in East Tennessee. Between 2002 and 2006 there were 401,871 babies born to Tennessee women. A total of 3,592 of these infants died during their first year of life, an average of 718 babies per year. This resulted in an infant mortality rate of 8.9 deaths for every 1,000 live births. This exceeded the national rate by 31.8 percent, due to the national infant mortality rate during this time period being estimated at 6.8 deaths per 1,000 births. FIMR is a community based process that collects data from multiple sources as well as interviewing the mother of the deceased fetus/infant. This information goes beyond a traditional factor analysis as the de-identified summaries are presented to community review and action teams to develop actions focusing on modifying the behaviors, lifestyles, and conditions that affect birth outcomes such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems and chronic illness that lead to low birth weight babies (less than 5 pounds 8 ounces) and premature births. The death rate for preterm infants was 44 per 1,000 births compared to 3.2 for full term infants. FIMR is committed to improve service systems and resources for women, infants, and families within the local community.

Dental Health: Dental services are required under EPSDT guidelines that are to be followed by the MCOs. There are significant shortages of dentists in MCO networks, and some areas of the state have no dental services available. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Fifteen projects have been approved for funding under this initiative. Many have chosen to develop mobile dental services targeting school children during the school year and providing services to others during holidays and summer. See NPM #9 for more information.

Help Us Grow Successfully Program (HUGS): Program goals are to reduce complications of pregnancy, subsequent unplanned pregnancies, developmental delays in children, and maternal and/or infant morbidity and mortality through home visiting services and a case management model. Services are targeted to prenatal and postpartum women up to two years after delivery (including women who have lost a child due to miscarriage, stillbirth, prematurity, SIDS or other causes) and children birth through the age of 5 years. These services assist clients in gaining access to health care (well-child checks, immunizations, EPSDT, WIC, etc.), psychosocial, educational and other necessary services to promote good health practices and improve general well-being. The program continues to expand services by working with the Child Fatality Review staff to receive referrals and provide services to women who have lost a child under age two. Services are provided to assist these women and their families cope with the grieving process and improve the outcome of future pregnancies. 22,851 visits were made in FY 2003, 32,467 in FY 2004, in FY 2005 38,895, in FY 2006 47,254, in FY 2007 52,722, in FY2008 55,574, and it is estimated to reach more than 57,000 in FY 2009. The increase in visits may be due to the additional staff added during FY 2004. The HUGS staff consist of 175 nurses, social workers and paraprofessionals as well as 14 Program Directors to coordinate seven regional, six metropolitan and one faith-based site. The program currently serves all of the 95 counties across the State of Tennessee. The program has expanded home visitation services to 6 additional counties. In addition, plans are underway to automate the data collection component.

Culturally Competent Care for MCH population
Tennessee like other states has had to modify services and increase resources to address culturally competent care for persons seeking health services through local health departments. The state has experienced a significant influx of foreign born residents over the past two decades. People of Hispanic origin are the largest group residing in the state and filling jobs in construction, landscape nursery, chicken processing and the service industry. Other racial/ethnic groups represented include Kurdish, Somalian, Sudanese and South East Asian; many are of the

Muslim faith requiring adaptation to cultural boundaries. Many of our county health departments have staff on hand to serve as translators -- especially for Spanish speaking clients. Most programs have print material available in Spanish; the metropolitan health departments have created or translated program material into several different languages (Arabic, Kurdish, Vietnamese, etc.) The Department contracts with Open Communications International (OCI) to provide over-the-phone translation services (mainly for languages other than Spanish) for rural health department clinics. Assistance with over 170 different languages is available. Through a toll-free number, interpreters can be accessed 24 hours a day. OCI has provided materials to all health departments to inform non-English speaking clients of this service and allow them to visually indicate their preferred language. The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. The Department has developed and implemented Title VI Policies and Procedures for limited English proficiency, which are applicable to all Health Services Administration programs that are receiving federal financial assistance.

State statutes relevant to Title V program authority are discussed as follows:

TCA 68-12-101-112 - The Crippled Children's Act of 1934 establishes state services for children with special health care needs who meet income and diagnostic guidelines. The Act further establishes an advisory committee and directs that certain geographic requirements be met.

TCA 68-5-401-503 - The Genetics and Newborn Screening Act establishes the statewide program responsible for screening and follow-up with all babies born who have questionable or confirmed lab results for genetic and inborn errors in metabolism.

TCA 68-142-101-109 - The Child Fatality Review Act of 1995 requires that review teams be established in each judicial district of the state and that all deaths to children under the age of 18 are reviewed. It further requires that an annual report is written and that a statewide advisory group is convened at least annually by the Commissioner to review findings and recommend policy.

TCA 37-3-703 - Established the Hawaii model of Healthy Start home visiting for families at risk of child abuse and neglect.

TCA 68-34-101-111 - The Family Planning Act of 1971 established the statewide family planning program, which included availability of contraceptives, eligibility for services, disposition of funds and services to minors.

TCA 68-142-201-209 -- Established the Tennessee Fetal and Infant Mortality Review Act of 2007.

Associated statutes related to maternal and child health issues include the following. The Traumatic Brain Injury Program (TCA 68-55-101¬402) establishes the head and spinal cord injury information system and advisory council; TCA 68-143-101-103 establishes a statewide public awareness campaign for shaken baby syndrome addressed jointly by the Departments of Health and Human Services. Tennessee was one of the first states to legislate child safety through the required use of child safety seats (TCA 55-9-602¬610), which took effect in 1977. The Child Bicycle Safety Act (TCA 55-52-101-106), passed in 1994, requires all operators and passengers under 16 riding on a state roadway to wear approved protective bicycle helmets and defines additional requirements for other riders. State statute declares it an offense to transport a child under 6 years old in the bed of a pickup truck on any roads of any county or state highway.

In 2000, TCA 49-1 authorized the establishment of the Coordinated School Health Program in schools in pilot counties; this school health program has expanded statewide for the nutrition and physical activity components. Department of Health personnel have been involved in developing the training video, guides, and manual on weighing and measuring students. In 2006 TCA 49-6 passed to require a minimum of 90 minutes of physical activity for students in all K-12 public

schools in the state.

State statutes passed during the 2008 session include:

TCA 49-5-415 provides direction on the administration of anti-seizure medications in school settings in emergency situations based on a student's individual health care plan. The statute describes the procedures to provide assistance with self-administration of medications by public and non public school personnel who volunteer and who have been properly trained by a registered nurse. The departments of health and education are directed to amend current "Guidelines for use of health care professionals and health procedures in school setting" to reflect the appropriate procedures for use by registered nurses in training volunteer school personnel.

TCA 68-1-124 directs the Department of Health to evaluate existing home visiting programs to determine which are evidence-based, research-based, and theory-based; to include in any contracts for home visitation programs the means to measure outcomes; and sets the framework for a pilot home visitation program that is evidence-based, research-based, and theory-based.

TCA 49, 68, and 71 directs the Department of Health, in consultation with the Department of Education and the Bureau of TennCare, to develop a comprehensive state plan to reduce the burden of asthma on Tennessee school children. The Department of Health is directed to study the prevalence and severity of asthma in Tennessee and determine whether a pilot project in a municipality with a high incidence of asthma should be developed.

TCA 68-5-9 requires that every newborn be screened for hearing loss prior to discharge from the birthing facility or prior to one month of age. Results are required to be reported to the Department of Health. TCA also requires coverage of the screening by insurance.

TCA 39-17-18 -- Tennessee Non-Smokers Protection Act made smoking illegal in all enclosed public places in the state with a few exceptions.

A mandate known as "Claire's Law", to require newborn hearing screening became effective July 1, 2008. Tennessee Code Annotated, Title 68, Chapter 5, Section 3-7, relative to health screening of children requires the following: 1) All children born in a hospital or birthing facility shall be screened for hearing loss prior to discharge from that facility. 2) The attending health care professional shall refer a child born in a setting other than a hospital (including home births) to an appropriate hearing provider. 3) The hearing screen should be conducted prior to discharge or before one month of age. 4) Any medical or audiologic provider performing follow-up tests shall report the results to the state program. 5) Tennessee Early Intervention System will assist in the follow-up of infants that do not pass the hearing screen and are in need of further hearing testing or may have a hearing loss.

An attachment is included in this section.

C. Organizational Structure

The Tennessee Department of Health is a branch of state government with a commissioner appointed by the Governor. There are thirteen regions under the state health department serving the 95 counties. Seven of the regions are comprised of rural counties, and six are comprised of metropolitan counties under the jurisdiction of metropolitan city councils/government. The counties in the seven rural regions are a part of the state's administrative system, whereas the six metropolitan counties are a part of the county administrative systems. Each county has a local health department with at least one clinic site. The central office of the Department, including Maternal and Child Health and Women's Health/Genetics, functions as the support, policy-making, and assurance office for the public health system. Central office program staff works closely with staff in both rural and metropolitan regions on all program activities. The primary difference between the two types of regions is the method used to provide funding. Rural regions

are part of the state government system, and metropolitan counties are separate city/county government systems. Both operate maternal and child health programs using the same standards and guidelines. The central office provides support and technical assistance to both rural and metro regions.

The Department of Health has a range of responsibilities, including administering a variety of community-health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into three bureaus and seven support sections. The Bureaus are Alcohol and Drug Abuse Services, Health Licensure and Regulation and Health Services Administration (HSA). The support sections include the State Laboratory, Office of Minority Health, Office of Policy, Planning, and Assessment, Office of Human Resources, Office of General Counsel, Office of Communications, and Office of Information Technology. The Maternal and Child Health Section and the Women's Health/Genetics Section are in the Bureau of Health Services Administration along with several other sections providing services across the state (Communicable and Environmental Disease Services, WIC/Nutrition Services, Community Services, General Environmental Health, HIV/STD, Medical and Dental Services, Regional and Local Health). /2009/ The Bureau of Alcohol and Drug Abuse services was moved to the Department of Mental Health and Developmental Disabilities. The third Bureau is now the Bureau of Administrative Services. The office of Minority Health became the Division of Minority Health and Disparities Elimination//2009//

Maternal and Child Health Services are housed within two sections of the HSA Bureau. MCH consists of Child and Adolescent Health Services, and Children's Special Services. Women's Health/Genetics consists of Genetics and Newborn Screening Services and Women's Health. Organizational charts for the Department, the Bureau of Health Services Administration, Maternal and Child Health, including Services for Children with Special Health Care Needs, and Women's Health/Genetics are available upon request.

The administration changed with the second term election of Phil N. Bredesen as Tennessee's 48th Governor in November 2006. In January 20, 2007, Governor Bredesen named Susan R. Cooper, MSN, RN., to serve as the Commissioner of Health.

Susan Cooper joined State government in September 2005 serving as special policy and health advisor, and was instrumental in developing Tennessee's Health Care Safety Net. She later assumed leadership of Project Diabetes, a program Governor Bredesen created to curb the Type II Diabetes threat facing young Tennesseans. Cooper also helped facilitate GetFitTN, the public awareness portion of Governor Bredesen's campaign to promote healthier lifestyles and habits among Tennesseans.

Before joining State government, Cooper was a faculty member and assistant dean at Vanderbilt University's School of Nursing, where she received both her bachelor and master of nursing degrees. Currently pursuing a Doctor of Nursing Practice from the University of Kentucky, Cooper has an extensive background in vulnerable populations, program planning and evaluation, health policy, healthcare regulation, and evidence-based practice. In addition to serving as a public health nurse, Cooper's career experience also includes work as a nurse specializing in emergency and intensive care.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN). Tennessee's local health departments in all 95 counties, carry out health related programs for women, infants and children. The Department of Health is responsible for the overall administration of the Maternal and Child Health Block Grant funding and all the programs, projects, and activities which are components of maternal and child health.

Funds that support MCH section activity include several special funding sources in addition to the MCH Block Grant. The state's award for State Systems Development Initiative (SSDI) has been used to develop the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since

SSDI funds were used to develop an integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used to upgrade the hardware and software used in the Genetic and Newborn Screening Program, which is under the direction of MCH and fulfills the state mandate to screen every baby born in the state for metabolic disorders.
/2009/ SSDI funding is currently being used to provide critical information from linked data sets to assist in programmatic decision-making. In addition, MCH has received funding since 2003 for the state's Early Childhood Comprehensive System program which replaced the CISS grant. //2009//.
Tennessee is one of 23 Centers for Disease Control and Prevention (CDC) Coordinated School Health funded partner grant recipients. The Department of Health Coordinated School Health works cooperatively with the Tennessee State Department of Education, Tennessee State Board of Education, State Universities, Local Education Agencies, School Health advocacy groups, and other interested parties in advocating and advancing the CDC's Coordinated School Health eight (8) component model in Pre-K through grade 12.

D. Other MCH Capacity

The Maternal and Child Health and the Women's Health/Genetics sections, like other sections of TDH, are organized into three levels of administration and service delivery. The Central Office, consisting of a staff of 36 professional and office support personnel, addresses strategic planning, policy development, program management, contract monitoring and data analysis functions. Staff are primarily located in the Cordell Hull Building in downtown Nashville which houses all the central office administrative offices of the Department, including the Commissioner's office and the Bureau of Health Services' central office. The seven rural regional offices are responsible for the health services offered in a specified geographic area (between 10 and 14 counties), and the metropolitan regional offices are responsible for the health services offered in each metropolitan county.
The Women's Health/Genetics staff who are responsible for newborn screening follow-up are located at the State Laboratory, which is approximately six miles from the downtown office. At both the central office and regional level, staff administers the programs mandated for women, infants and children and handle all the administrative functions including personnel management, fiscal management, systems development for the Patient Tracking Billing Management Information System (PTBMIS), outreach and coordination with other health service systems including TennCare. Staffs at the regional and local health department levels are under the supervision of the regional director and his/her staff and are not considered out-stationed central office staff.
Within central office, Maternal and Child Health Services is organized into two primary areas, Child and Adolescent Health and Children's Special Services. The section chief is Theodora Pinnock, M.D. Dr. Pinnock is a pediatrician and completed a fellowship in developmental and behavioral pediatrics. As Assistant Professor of Pediatrics at Vanderbilt Medical Center, she spent five years working in family centered, community and school-based family resource centers focused on maximizing children's readiness for school. ***/2010/ Dr. Pinnock resigned in February 2009. Cathy R. Taylor, DrPH, MSN, RN, Director, Assistant Commissioner Bureau of Health Services, is serving as the Interim MCH Director. Dr. Taylor's CV is in the attached file. Mary Jane Dewey and Margaret Major are serving as operational managers for the MCH section.//2010//***
Child and Adolescent Health Services - This area has several major programs headed by Master's level directors with over five years public health programmatic experience. These programs include Childhood Lead Poisoning Prevention, Asthma Management Program, Child Health and Development(CHAD), Adolescent Health and Young Adult Health, SIDS, Help Us Grow Successfully (HUGS), School Nurse, Healthy Start, Child Fatality Review and Early Childhood Comprehensive Systems.

Children's Special Services (CSHCN) --Jacqueline Johnson, BS, MPA, has served in a variety of

roles working with children. Her career in public health has been solely with Maternal and Child Health Services. In 2005, Ms. Johnson began working as a public health program director for the Childhood Lead Poisoning Prevention Program, the SIDS Program and the Child Fatality Review Program. Ms. Johnson has a masters degree in Public Administration, as well as a significant number of masters level hours in special education. Ms. Johnson was named State CSS Program Director in November 2007.
The other MCH programs, Genetics and Newborn Screening and Women's Health are housed in the Women's Health/Genetics Section. Margaret F. Major, MPA, RD, serves as section chief for the women's health and genetics programs and has worked in public health programs related to women and children since 1969. After 3 years of working in Brazil with international nutrition programs, she joined the Tennessee Department of Health in 1972, working in community nutrition programs, maternal and child health, family planning and women's health. Her current program responsibilities include family planning (Title X), perinatal regionalization, prenatal care, adolescent pregnancy prevention program, women's health, newborn metabolic screening, newborn hearing screening, and genetics and sickle cell centers.

Genetics and Newborn Screening Services --Cindy Wallace joined Women's Health and Genetics as the Program Director for Genetics, Newborn Screening, and Newborn Hearing Screening in 2007. Ms. Wallace has a master's degree in public services management and is certified as a medical technologist supervisor. She has worked as the manager of the State's Newborn Screening Laboratory, been an assistant professor in a state university's medical technology program, and has worked in the Department of Health for 13 years. The metabolic newborn screening follow-up program activities are headed by a master's level nurse with twelve years of experience with the program, and 34 years of experience in nursing. The newborn hearing screening follow-up program is headed by a nurse who has been director of the program for over 6 years and has 28 years of nursing experience, all of which has been public health settings.

Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are created and maintained by their staff. These data sets include birth files, death files, linked birth-death files, hospital discharge, PRAMS, and the birth defects registry. WIC files are a component of the Patient Tracking Billing Management Information System (PTBMIS) which is maintained by the Bureau of Health Services. MCH staff has access to the output data within the PTBMIS files through a system of data CUBES. Staff in Health Services and the Office of Policy, Planning, and Assessment are available for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and hearing screening are handled through the Neometrics system for the follow-up program and the State Laboratory.
Personnel from MCH and PPA have teamed up to implement the Tennessee State Systems Development Initiative (SSDI) objectives. These objectives include linking of birth and death files, utilizing geocoding to identify disparities and areas to target for children with elevated blood lead levels, and linking birth certificates to newborn screening information and congenital birth defects. In addition, goals include linking birth certificates and PRAMS data; and linking birth certificates and FIMR data.

Role of parents: Parents are involved in all aspects of care provided to children and youth receiving services from the Children's Special Services Program. Care Coordinators are assisting families with referrals for needed services to available community agencies or the Mothers Understanding Mothers (MUMS) program. A parent serves on the CSS Advisory Committee for the program.

The Newborn Hearing Screening (NHS) Program works closely with other organizations that include the March of Dimes, Tennessee Disability Coalition, Family Voices, Tennessee Deaf/Blind Project (TREDS), Tennessee Association of Audiologists and Speech Language Pathologists (TAASLP), Tennessee Audiology Association, and the Tennessee Early Intervention

System. Partners that are to be recognized for the passage of the bill include "Claire's" parents Michelle and Matt Puryear, March of Dimes, the Tennessee Disability Coalition, Tennessee Hospital Association, and the Tennessee Association of Audiologists and Speech Language Pathologists (TAASLP). NHS works with other Department of Health programs including the Office of Policy Planning and Assessment, Children's Special Services (Title V CYSHCN), and Newborn Metabolic (Blood spot) Screening.

The Newborn Hearing Screening program includes a component to provide family support to infants and toddlers identified with hearing loss. Services are provided by three part-time newborn hearing parent consultants. They are located in each of the three grand regions of the state. There are plans to add a bilingual (Spanish) family consultant to the program in September 2009. Consultants are parents and families members of children with hearing loss. They are contracted through Tennessee Disability Coalition/Tennessee Family Voices, an organization that provides support to families of children with any disability. Consultants have several goals: link families to support each other; build and strengthen family networks; increase resources such as support groups; identify resources for families of children with hearing related conditions; participate in program and policy development; and provide educational materials to the community, medical providers, hospitals, audiologists, and other organizations. The FLASH Family Support group in the Knoxville area is parent run and very active in providing monthly educational and support activities. Parents attended the CDC/HRSA Early Hearing Detection and Intervention (EHDI) conference in March 2009. 6 parents attended the Third Annual Investing in Family Support Workshop October 2008, sponsored by the National Center for Hearing Assessment and Management (NCHAM). Parents play an active role in the development of newborn hearing guidelines for hospitals, audiologists and early intervention. Parents were active to promote obtain newborn hearing legislation to mandate hearing screening in hospital prior to discharge. The new "Claire's Law " is named after the daughter of a very dedicated and involved parent. A team of parents completed a new Family Information Packet, May 2009, to be given to families of infants and toddlers diagnosed with hearing loss. Parents serve on the Newborn Hearing Screening Task Force.

An attachment is included in this section.

E. State Agency Coordination

Maternal and Child Health and Women's Health staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, with other governmental departments and agencies, and with organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, Arthritis Foundation, Tennessee Suicide Prevention Network, State Minority Health Task Force, and the Council for Developmental Disabilities).
MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Assistant Commissioner, Bureau of Health Services Administration.
TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers

within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CYSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services. All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees. The Newborn Genetic/Metabolic Screening and Hearing Screening programs provided training to the TennCare Managed Care Organization EPSDT Coordinators on screening requirements, confirmatory diagnostic testing and follow-up systems.

Department of Children's Services (DCS): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include funding for both the Healthy Start and Child Health and Development home visiting programs. MCH gets referrals from DCS and makes home visits to the family. Also, DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators staff work with the DCS Regional Health Unit nurses to coordinate health services for CYSHCN in state custody.

MCH staff are members of the Children's Justice Task Force and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse.

Department of Human Services (DHS): DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices currently serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. In addition, MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers. /2009/ In 2007-2008, MCH enhanced its services to DHS by providing collaborative support to prevent childhood obesity and promote good social emotional development in child care populations. //2009//.

Department of Education (DOE): The directors of adolescent health and adolescent pregnancy prevention serve on the advisory committee of the Coordinated School Health (CSHP) Program. Staff are working with the CSHP director to plan school-based child obesity prevention programs in conjunction with the LeBonheur Hospital school health team in Memphis. In 2006, DOE and MCH continued their joint five year CDC grant to expand coordinated school health programs throughout the state. For FY 2006-07, they will be conducting meetings with educational stakeholders to promote the development of more coordinated school health programs, revising the State's Wellness and Physical Activity Plan. In addition, the MCH director currently serves on the recently established Early Pre-K Education Committee, which is currently restructuring policy for the State's early pre-K programs.

The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 years old identified with or having a potential for a developmental delay. TEIS has been an active participant in collaboration with the CSS program since 1990. The programs coordinate referral and care

coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council representing all MCH programs. TEIS staff serve on the NHS Task Force and the genetics implementation grant committee and have participated in joint in-services with CSS and NHS. The Tennessee Infant Parent Services (TIPS) program trains Parent Advisors to provide home-based services to infants and toddlers birth to 5 years identified with a vision and/or hearing loss, or other disability. TIPS and TEIS work closely with the NHS program and provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. The TEIS data collection system documents hearing follow-up and will link to NHS. An MCH staff serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CYSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care.
Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program and the Early Childhood Comprehensive Systems Advisory Committees. These committees include state agency staff and advocates for children and meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors have been invited to attend the MCH video-conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children.
Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. CSS includes an assessment of a child's psychosocial development and refers CYSHCN and family members to local mental health centers or other local mental health providers if appropriate. Mental health and social-emotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee.. MCH's Adolescent Health Program Director is currently assisting in implementing a suicide prevention training grant recently received by TMHDD.
The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth suicide prevention. The committee developed a state plan to address youth suicide prevention.
Social Security Administration (SSA): MCH staff provide information on MCH programs to parents of CYSHCN who have applied for SSI. The CSS program coordinates referral of children whose names are received from the SSA. The parent or guardian is sent information about possible services available to their child from state programs (CSS, Mental Health, Mental Retardation, TEIS, and the regional genetics centers).
Tennessee Bureau of Investigation (TBI): TBI staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CYSHCN constructed at no cost to families.
Vocational Rehabilitation: See Department of Human Services.
The Commission on National and Community Service coordinates state volunteer efforts. The adolescent health director represents the Department of Health on this commission. Members include representatives from the public and private sector who are engaged in promoting volunteer services throughout Tennessee. This MCH staff person has assisted commission members and staff as they explore the feasibility of Tennessee becoming a "State of Promise" through the America's Promise initiative.
Child Fatality Review: The Child Fatality Review process is a statewide network of multi¬discipline, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths

of children 17 years of age or younger. Members of the local teams include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.
/2009/ A representative from the Department of Education was legislatively added to the State team. //2009//.
Childhood Lead Poisoning Prevention Program: Collaborating agencies include: a) University of Tennessee Agricultural Extension Service which provides social marketing to develop and distribute information on childhood lead poisoning to health departments and extension agents, and surveillance system assistance to analyze child blood lead level data and assist staff, partners and health care providers regarding medical case-management of children with elevated levels; and b) Tennessee Department of Environment and Conservation to conduct environmental investigations.
Adolescent Health: The adolescent health director serves on the Tennessee Healthy Weight Network. This network represents a public/private partnership of over 30 state and private organizations committed to addressing the obesity epidemic within Tennessee.
Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are 24 Federally Qualified Health Centers (FQHC) that operate 118 clinic sites in Tennessee. These community health centers, which provide primary health care, dental and mental health services to more than 270,000 patients who became a part of the "safety net" to help those dropped from TennCare. Referral systems exist between those community health centers and health departments located within the same county.
Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT): Since July 2001, local health department clinics have assisted TennCare by providing EPSDT screenings to TennCare enrollees. The TennCare Program had difficulty in achieving desired EPSDT screening rates and is partnering with the Department to improve these rates. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics representatives.
Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The state folic acid coordinator serves as chair of the state council. The Women's Health director serves on the state council.
HIV/AIDS/STD: There is strong collaboration between the staff of the Women's Health and HIV/AIDS/STD sections. Family planning staffs make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS. With the integration of services at the local levels and the multiple functions performed by staff in the clinics, staff are very familiar with Women's Health and HIV/AIDS/STD programs. The Infertility Prevention Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory.
The Tennessee Breast and Cervical Cancer Early Detection Program (TBCCEDP): This program provides breast and cervical cancer screening, diagnosis and treatment to uninsured women over age 50. About 14,000 women are screened annually and enrolled in TennCare, if necessary, for treatment. The program accepts referrals of any age from family planning for diagnostics.
Office of Nursing: MCH and Women's Health central office nursing staff routinely provide program updates at their quarterly statewide Nursing Directors' meetings. They also serve as consultants to answer health questions related to their respective programs i.e., Family Planning, SIDS, Lead

Poisoning Prevention, Home Visiting, etc.
Health Promotion and Nutrition/WIC: Collaborative efforts among MCH and Women's Health staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women include advertising the availability of the state's QUITLINE and other educational activities. CSS makes direct referrals to WIC on all clients under 5 or mothers of CYSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for PKU children.
Office of Policy, Planning and Assessment: Central office staff collaborate with the Health Statistics section on dissemination of annual releases of health data and special reports, collection of data through the joint Annual Report of Hospitals, collection of data for the Region IV Women and Infant Health Data Indicators Project, and in other MCH data projects. Women's Health staff are coordinating with this office on upgrading the newborn hearing screening data system. MCH and this Office will collaborate to implement the SSDI 2006-2011 grant.
Tennessee Adolescent Pregnancy Prevention Program: TAPPP councils operate in four of the six metropolitan areas and in multi-county groupings in 6 of the 7 rural regions. The 10 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent heath fairs, workshops, legislative briefings, and training for professionals.
Tennessee Primary Care Association (TPCA): Department staff work closely with the TPCA primarily through the Office of Health Access, Regional and Local Health Councils, and the Women's Health Advisory Committee.
Other federal grant programs under the administration of the Department, such as WIC, Family Planning, lead and Newborn Hearing Screening, are discussed in other sections.
/2009/The CISS grant and the Abstinence Education only program have been eliminated. //2009//.
Identification of pregnant women and infants eligible for Medicaid: All local health department clinics provide pregnancy testing and presumptive eligibility for Medicaid. If presumed eligible, client data are entered directly into the TennCare database at the local health department site. Women's Health staff answer the toll-free number (Baby Line) which provides information and referrals for prenatal care. Pregnant women enrolled under presumptive eligibility are referred to DHS for further enrollment beyond the presumptive time period. Also, TENNderCare Nursing call center answer the Live to 1 toll-free number set up to answer questions from citizens concerning the reduction of infant mortality.

F. Health Systems Capacity Indicators

Introduction

Following each indicator a brief narrative refers to those sections of the document which provide information on the indicator or includes information relative to the indicator. Data and data sources are noted on the forms.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	58.6	28.9	28.9	29.6	29.0
Numerator	2288	1366	1366	1188	1155

Denominator	390312	473085	473085	400744	398283
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is Hospital Discharge, Tennessee resident only, and population estimates.

Notes - 2007
Data source is Final Inpatient Hospital Discharge Tennessee resident only and 2007 population estimates.

Notes - 2006
Data source is Hospital Discharge Tennessee resident only and population estimates

Narrative:
The Bureau of TennCare has recognized asthma as being a high cost diagnosis through the managed care system. As a result of a TennCare Asthma Summit with a representatives from all Managed Care Organizations (MCOs), recommendations were made on addressing asthma. Those recommendations were published in an Asthma Care Management Program, including quality improvement measures and provider and client educational materials. All are available to providers on-line. /2009/ In 2008, legislation was passed which called for the development of a comprehensive State plan. In addition, the Department of Health published a report on the burden of asthma in the State. //2009//.
/2010/ The Tennessee State legislature passed a law, Public Chapter 1154 in 2008 mandating development of a comprehensive state plan to reduce the burden of asthma among Tennesseans with a particular focus on children. The State of Tennessee Asthma Task Force (STAT) was convened to develop The STAT Plan to Reduce Asthma in Tennessee, 2009. The task force is comprised of like-minded agencies and professionals from across the state including the Department of Health, the TennCare Bureau, and the American Lung Association of Tennessee. STAT members examined The Burden of Asthma in Tennessee document and developed specific goals, objectives and evidence-based interventions strategies with measurable outcomes to address needs and inequities. The overarching goal of the State of Tennessee Asthma Plan is to reduce the burden of asthma in Tennessee. To this end, the Plan seeks to improve: (1) continued surveillance of asthma to identify needs and gaps in asthma management; (2) public awareness and education as a public health problem; (3) medical management of asthma as a chronic disease by both the health care provider and the patient, and (4) reduction of indoor and outdoor environmental triggers relevant to asthma management and control. Focus areas include: (1) Surveillance and Epidemiology; (2) Public Awareness and Education; (3) Medical Management; and (4) Environmental Management. STAT applied for funding through the Centers for Disease Control and Prevention National Asthma Control Program in the amount of $500,000 for FY 2009. The targets populations are: (1) Children 0-5 years old and their caregivers and families; (2) School age children 10 years and younger including their parents and the school environment; and (3) Tennesseans age 30 and older. The STAT and Department members also collaborated with other southern states to share best practices at the Asthma in America Regional Conference held by the Public Health Foundation in November 2008. //2010//.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	77.5	66.8	62.9	83.6	83.6
Numerator	38116	52414	53033	48559	48559
Denominator	49159	78503	84277	58058	58058
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
State of Tennessee Tenncare (Medicaid) database.
Data source is the state of Tennessee TennCare EPSDT Data system.
Data is 1 year late due to TennCare EPSDT reports.

Notes - 2007
State of Tennessee TennCare (Medicaid) database

Notes - 2006
State of Tennessee TennCare (medicaid) database

Narrative:
#2.Health Systems Capacity Indicator - Percent of Medicaid enrollees less than one year of age who received at least one initial screen: The state's emphasis on EPSDT screening for all TennCare children is discussed in various sections of this document. (See Agency Capacity, NPM #13, NPM #14, and SPM #7) The EPSDT Community Outreach Initiative and Call Centers are designed to increase the number of eligible children receiving screenings and are described in the progress report sections on EPSDT.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.0	0.0	0.0	0.0	95.5
Numerator	0	0	0	0	535
Denominator	1	1	1	1	560
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
These data are those SCHIP children 0-1 on TennCare/SCHIP; total number and those who received at least one EPSDT screen during the year. In addition to these children, SCHIP funds

were used for 5,086 member months for ages 0-1 in CoverKids (see section III.A and NPM 13 for details on CoverKids); during this period there were 1,890 well child encounters. CoverKids does not require or track EPSDT screenings for members.

Notes - 2007
2007 data are not available; however, SCHIP children in Tennessee are enrollees in both TennCare and in CoverKids.

Notes - 2006
Tennessee does not have a separate SCHIP program.

Narrative:
#3 Health Systems Capacity Indicator -- Percent of State Children's Health Insurance Program (SCHIP) enrollees less than one year of age who received at least one periodic screen: Data from TennCare on those children ages 0-1 considered to be SCHIP enrollees indicate that 95.5% received at least one EPSDT screen during the time period. Additional SCHIP children are enrollees in CoverKids, Tennessee's program for uninsured children age 18 and younger. See section III.A and NPM 13 for additional information on CoverKids or the web site for CoverTn (www.CoverTn.gov). CoverKids does not require EPSDT screening for enrollees, nor does the program track screens.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	78.5	74.1	76.8	83.8	85.6
Numerator	61783	60360	64738	72498	73144
Denominator	78696	81454	84277	86558	85443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 Provisional Birth Master files.

Notes - 2007
Data source is Tennessee Birthmaster file resident only

Notes - 2006
Data source is Tennessee Birthmaster file resident only

Narrative:
#4.Health Systems Capacity Indicator- Prenatal visits using the Kotelchuck index: Information on the state's activities and programs addressing the needs of pregnant women is included in Agency Capacity, Other Program Activities, and NPM #8, 15, and 18.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	100.0	100.0	100.0	45.9	45.9
Numerator	775232	758628	743387	375016	375016
Denominator	775232	758628	743387	816486	816486
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Methodology and data source changed for 2007 and 2008.
Numerator - Actual Medicaid data on number receiving a service are not available. As a proxy, used CMS-416 Report, FY 2007, line 9, "Total eligibles receiving at least one initial or periodic screen."
Denominator - Kaiser Family Foundation, TN, Ages 0-19, < 100 % poverty, 2006-2007 (Used as estimate).

Notes - 2007
Methodology and data source changed for 2007 and 2008.
Numerator - Actual Medicaid data on number receiving a service are not available. As a proxy, used CMS-416 Report, FY 2007, line 9, "Total eligibles receiving at least one initial or periodic screen."
Denominator - Kaiser Family Foundation, TN, Ages 0-19, < 100 % poverty, 2006-2007 (Used as estimate).

Notes - 2006
Data source is State of Tennessee TennCare (medicaid) data based on eligibility. Data is based on estimation

Narrative:
#07A. ***/2010/ The state has placed great emphasis on decreasing the number of children without insurance coverage. Families are encouraged to apply for Medicaid or for CoverKIDS. Families requesting WIC or Children's Special Services are encouraged to apply for TennCare. Families with enrolled children in TennCare are encouraged to get preventive care for their children in accordance with EPSDT guidelines.//2010//***

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	51.4	60.4	37.0	50.6	50.6
Numerator	72563	86569	56418	77255	77255
Denominator	141136	143367	152680	152575	152575

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data sources are the state of Tennessee TennCare EPSDT Data system.
Data are 1 year late due to TennCare EPSDT reports.

Notes - 2007
Data source is the state of Tennessee TennCare EPSDT Data system.
Data are 1 year late due to TennCare EPSDT reports.

Notes - 2006
State of Tennessee EPSDT database.

Narrative:
#07B. Health Systems Capacity Indicator - ***/2010/ Dental services for children are described in NPM #9 and Agency Capacity. The number of children on TennCare ages 6 to 9 eligible for EPSDT services and receiving dental services increased significantly from past years to 2007 (77,255). //2010//***

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100.0	100.0	100.0	9.0	14.0
Numerator	19097	19781	22392	1962	2838
Denominator	19097	19781	22392	21881	20343
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.

Data sources are CSS program database and federal database of SSI recipients.

Notes - 2007
For both 2007 and 2008, the methodology and data sources were changed in response to directives received at the block grant review.
Data sources are CSS program database and federal database of SSI recipients.

Notes - 2006
Data source is the Federal progam data of State SSI recipients.
Data is based on true number receiving services.
There is change in data methodology since the data was taken from the Federal program SSI database. The Numerator and Denominator are from the Federal SSI database. All numbers are for year 2006.

Narrative:
#8. Health Systems Capacity Indicator - ***/2010/ SSI beneficiaries less than 16 in the state receiving services from the children with Children with Special Health Needs Program: All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Forty-one percent of the 5,802 CSS enrollees have SSI (FY 2008). Program staff continues to contact families with newly diagnosed children and provide information on services available. Data for 2008 indicate 20,243 SSI recipients in the state; 2,838 were contacted by CSS staff. //2010//***

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	10.4	7.4	9.4

Notes - 2010
Data linked 2007 birth certificate and TennCare file (Medicaid)

Narrative:
#5. Health Systems Capacity Indicator-***/2010/ Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index or entry into prenatal care for the TennCare enrollees. Comparisons of the other two data elements consistently show that the total population has lower low birth weight and infant mortality rates than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age. //2010//***

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Infant deaths per 1,000 live births	2008	matching data files	10	6.7	8.3

Notes - 2010
Data linked birth certificate and TennCare file (Medicaid)

Narrative:
#5. Health Systems Capacity Indicator-***/2010/ Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index or entry into prenatal care for the TennCare enrollees. Comparisons of the other two data elements consistently show that the total population has lower low birth weight and infant mortality rates than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age. //2010//***

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	0	0	85

Notes - 2010
Data are not available from the Medicaid agency or from a matched data file to provide information on prenatal care to the Medicaid and Non-Medicaid populations.
The Medicaid and Non Medicaid column with zero indicates that there are no data available for the category.
Data source is Vital Records since we are not able to use a matched data file.

Narrative:
#5. Health Systems Capacity Indicator-***/2010/ Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index or entry into prenatal care for the TennCare enrollees. Comparisons of the other two data elements consistently show that the total population has lower low birth weight and infant mortality rates than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age. //2010//***

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	0	0	74.1

Notes - 2010
Data are not available from the Medicaid agency or from a matched data file to provide information on prenatal care to the Medicaid and non-Medicaid populations.

The Medicaid and Non Medicaid colum with zero indicates that there are no data available for the category.

Data source is Vital records since we are not able to use a matched data file.

Narrative:
#5. Health Systems Capacity Indicator-***/2010/ Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index or entry into prenatal care for the TennCare enrollees. Comparisons of the other two data elements consistently show that the total population has lower low birth weight and infant mortality rates than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age. //2010//***

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	250

Notes - 2010
Data are from TennCare (Medicaid) website.

Notes - 2010
Data are from TennCare (Medicaid) website

Narrative:
#6. Health Systems Capacity Indicator - ***/2010/ Poverty level eligibility for Medicaid and for SCHIP: Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program. //2010//***

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 250 250

Notes - 2010
Data are from TennCare (Medicaid) website.

Notes - 2010
Data are from TennCare (Medicaid) website.

Narrative:
#6. Health Systems Capacity Indicator - ***/2010/ Poverty level eligibility for Medicaid and for SCHIP: Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program. //2010//***

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Pregnant Women	2008	250

Notes - 2010
Data are from TennCare (Medicaid) website.

Notes - 2010
Data are from TennCare (Medicaid) website.

Narrative:
#6. Health Systems Capacity Indicator - ***/2010/ Poverty level eligibility for Medicaid and for SCHIP: Medicaid coverage in Tennessee continues to include: SSI eligible, TANF eligible, medically needy eligible, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty. SCHIP enrollees are in the Coverkids program. //2010//***

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2010

Narrative:
#9A Health Systems Capacity Indicator-Ability of states to assure that the MCH program and Title V agency have access to policy and program relevant information and data: Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. The state began collecting data for the CDC funded Pregnancy Risk Assessment Monitoring System (PRAMS) in May 2007. This new system is housed in PPA. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in the Bureau of Health Services and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data for newborn metabolic and hearing screening are handled through the Neometrics system for Women's Health/Genetics and the State Laboratory.

Sections such as MCH do not have direct access to data, but have access through PPA or the Bureau of Health Services (HSA). The PPA staff epidemiologists work with the section to provide needed data, to improve the quality and quantity of data sets available, and to develop the interest and commitment to address state health status issues through specific studies of data. The staff in HSA provide data and support to MCH staff for the PTBMIS data system.

Tennessee participates in the Youth Risk Behavior Surveillance System (YRBS). The survey is administered by the Department of Education every two years. The data results are available to MCH staff. Because Tennessee does not administer the Middle School YRBS statewide, there is a gap in information on this age group. Shelby County, with special funding, was able to do a one-year YRBS in Middle Schools; the data were extremely useful. The data from vital statistics and the YRBS are used to develop and update the State's Adolescent Report which was first published in 2006 and has biannual updates.

The Genetics and Newborn Metabolic and Hearing Screening Programs use propriety software from Neometrics to manage program data. The Case Management System contains data on all abnormal metabolic screening results, demographics on the infants, and information on follow-up and treatment. The system generates a letter to both the parents and the primary care provider to repeat the specimen. The system allows tracking of each hospital's rate of unsatisfactory specimens. The Department is developing an ongoing process to link these data to the birth files. The system also is used for tracking newborn hearing screening results and follow up -- also linking to birth files.

The Tennessee Birth Defects Registry (TDBR) is a system housed within PPA. The first annual report of Tennessee Birth Defects was completed for 2000-2002. The TBDR has initiated a system that involves sending public health nurses to selected hospitals to review infant medical records. The active review of medical records provides a depth of information not available through other passive sources (e.g., birth files and hospital discharge information). The TBDR is working toward adding birth defects information to the Department's web site. The TBDR data are the combined product of passive surveillance based on hospital discharge records and active medical records reviews conducted by public health nurses. Birth defects registry documents are on the Department of Health's web site.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)

Youth Risk Behavior Survey (YRBS)	3	No
Pediatric Nutrition Surveillance (PedNSS)	3	No
WIC program data	3	No
PRAMS	3	No

Notes - 2010

Narrative:
#09B Health Systems Capacity Indicator - ***/2010/ Percent of adolescents in grades 9 through 12 who report using tobacco products in the past month as determined through participation in the Youth Risk Behavior System: Information on this indicator is in SPM #3. Data are obtained from the Youth Risk Behavior Surveillance System and available every two years. The survey is the responsibility of the Department of Education. The data results are available to MCH and staff through the close working relations of the adolescent health director in MCH and staff in the Department of Education.//2010//***

IV. Priorities, Performance and Program Activities

A. Background and Overview

The federal government and Tennessee partner to improve services and activities for the MCH populations in need. The process of developing a needs assessment, planning, designing and implementing programs, and allocating resources is a critical part of the public health system in Tennessee. Tennessee continues to address its priority areas as determined through last year's Needs Assessment.

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for women, infants and children. The primary emphasis of all health department activity is to assure that women, infants, and children receive the preventive care they need to reduce morbidity and mortality. In response to the changes in the TennCare program, primary care capacity has been expanded in the Department of Health by 100%.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing, sexually transmitted disease screening, HIV counseling and testing, and family planning services are available in every county. All counties operate WIC and nutrition services. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child screenings in compliance with EPSDT. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental, household inspection and lead abatement activities with the families.

/2009/ The Department received ten million dollars from the state and launched a tobacco cessation program targeted at pregnant women and teens who smoked. All local health departments are participating in this initiative.//2009//.

/2010/ The Legislature approved $5 million in state dollars to continue the Tennessee Tobacco Use Prevention and Cessation Initiative for the year ending June 30, 2009; however, due to the budget shortfall the dollars were subsequently redirected. //2010//

For children and youth with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be located for follow-up. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed medical and referral services.

Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and advocacy, determining presumptive eligibility for pregnant women and women with breast or cervical cancer, assistance with the appeals process, referring all CSS children for TennCare enrollment, and assuring that those presumptively eligible for prenatal care are receiving needed services. The care coordination component of CSS provides special support and enables families to better meet their child's needs in a complex health care environment. In addition, outreach activities have been expanded to address decreasing infant mortality.

/2009/ The Help Us Grow Successfully (HUGS) program expanded its workforce by 17 percent to help address infant mortality.//2009//. ***/2010/ HUGS services are now available in all 95 counties. //2010//***.

Population based services are available through the activities of MCH, Women's Health, Nutrition, Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than individuals. Examples include: newborn metabolic screening for all newborns; newborn hearing screening follow-up; surveillance for sexually transmitted diseases; adolescent health; childhood lead poisoning prevention program; the child

fatality review system; SIDS counseling and autopsies; and adolescent pregnancy prevention program. Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and provide treatment. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality.
Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines. Assessment for health planning is a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups develop and update implementation plans and activities to address these priorities on the local level. The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The data and systems planning functions have been greatly enhanced with the availability of SSDI funds which have been used to provide support for the statewide computer network. ***/2010/ State is in year 2 of implementing PRAMS, continues the Birth Defects Registry, and is starting Fetal Infant Mortality Review teams in 3 metro counties and one rural region.//2010//***.
Training of regional and local staff is a key role of the central office. In collaboration with Vanderbilt University's MIND (Mid-Tennessee Interdisciplinary Instruction in Neurodevelopment Disabilities) Training Program, MCH continues to provide interactive training on MCH programs and health issues through video-conferencing statewide. MCH wanted to be assured that CSS and other health department staff were appropriately trained. Ten to twelve videoconferences are held each year addressing current information on specific diseases and conditions, along with the treatment or clinical applications. Topics addressed in 2005-06 were infant mortality, epilepsy, nutrition in CYSHCN, information technology resources and developmental assessment. /2009/ Topics addressed in 2007-08 were bioterrorism and individual preparedness, autism, ethics in home visiting, Fragile X, newborn screening, and FIMR/PRAMS information.//2009//. ***/2010/ Topics for FY2009 included autism, newborn hearing screening, child abuse, preconception health, and medical records documentation.//2010//***.

B. State Priorities

In the 2005 Needs Assessment process, Tennessee established ten priority areas. Six of the areas remained priorities as they had been focused on during the FY 2000-2005 period. Four areas were new and reflected the Commissioner and Department of Health's direction, as well as direction from the governor.
The state's identified performance measures are listed as follows:

1. Increase percentage of children with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.
2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.
3. Reduce the number of babies born prematurely.
4. Reduce the number of pregnant women who smoke and use illicit drugs. ***/2010/ SPM 4 has been deleted due to similarity to NPM 15. //2010//***.
5. Reduce the number of overweight and obese children and adolescents.
6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics.
7. Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.
8. Reduce the number of high school students using tobacco. (cigarettes and smokeless)
9. Reduce the number of high school students using alcohol.
10. Increase the percentage of youth with special health care needs, age 14 and older, who

receive formal plans to transition to adulthood.
Priority setting is a continual process. With the current Administration in place, the Department has started a new strategic planning process. The Governor outlined his priorities for State Government. Two of these directly relate to health department activities and services. The Governor strongly believes every child deserves to grow up healthy and happy. He wants the state to work with families, agencies and foster parents to help protect children. He created a Children's Cabinet to encourage better cooperation between health agencies and nonprofit agencies responsible for children's welfare, including TennCare and the departments of Children's Services, Education, and Health. In June 2004, the Governor created the Governor's Office of Children's Care Coordination (GOCCC) to coordinate the wide range of services and supports available to children through state departments and the private sector.
/2009 The GOCCC completed recommendations in Spring 2007 for a complete reform of the Tennessee Early Intervention System (TEIS: IDEA Part C program for children birth to 3 years with developmental delays) that were accepted by DOE Commissioner Seivers and fully implemented by October of that year. Since then the GOCCC and leadership of TEIS have begun working with the TennCare Managed Care Organizations to better link MCO case management with TEIS service coordination for infants and families discharged from neonatal intensive care units and to promote medical homes for all families enrolled in TEIS.

The GOCCC is also working to develop the state's infrastructure to support evidence-based practices in multiple settings. The Centers of Excellence for Children In or At Risk of State Custody have been engaged in a learning collaborative in which Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been implemented with fidelity in 32 agencies with 162 mental health practitioners/supervisors participating. Five hundred and ninety-two cases are currently using TF-CBT. An interdepartmental analysis lead by the GOCCC referred to as the Collaborative on Funding and Administration of Adolescent Substance Abuse Services concluded in November 2008 with a set of recommendations adopted by the leadership team of department commissioners. That work product included matrices of evidence-based practices for school-based prevention programs, screening tools, assessment tools, treatments and interventions. The GOCCC has led a workgroup of the Council on Children's Mental Health which developed a definition of and criteria for Evidence-Based Practices that will be adopted by all the departments and agencies participating in the Council.

Several programs aimed to reduce infant mortality sponsored by the GOCCC showed promising results. A Centering Pregnancy project in Memphis yielded 32 out of 36 infants born at normal weight and without perinatal complications. Tennessee Intervention for Pregnant Smokers (TIPS), a tobacco cessation program for pregnant mothers, preliminarily showed a significant reduction in prenatal and postnatal smoking and in August of 2008, the program further resulted in a 30% cessation rate.//2009//.
The Governor restructured TennCare benefits as the way to continue providing needed health services to many Tennesseans. Two priorities address management of state government. The Governor believes that the way to avoid a budget crisis is to change the way state government works. He has been examining state government from top to bottom to find savings and identify more efficient practices. He stated that strong management of state government begins with earning the taxpayer's trust, including establishing accountability in all state agencies.
In 2006, Governor Bredesen proposed his "Cover Tennessee" initiatives to offer affordable health care insurance to employees of small businesses; expanded the State's current SCHIP eligibility; and provide disease management services to persons with diabetes. The expansion of SCHIP may potentially double the current number of children eligible for such services.
/2009/ The Cover KIDS program began enrollment in March 2007. See Overview //2009//.
In 2005-06, Governor Bredesen strongly supported education by increasing, teacher pay, increasing school district funding, doubling the capacity of his early pre-K program from 100 to 250 classrooms. /2009/ In 2006-07 Governor Bredesen added 250 more pre-K classrooms. More classrooms were projected for the FY2007-08 year but were not funded due the state funding crisis.//2009//.
In light of a series of scandals involving public officials, Governor Bredesen promised strong

ethics policies. He held a special session of the Legislature and issued several executive orders to support the establishment of such policies.
In 2004, the Governor and the Commissioner of Health issued a wake-up call to all Tennesseans to start living healthier and make more responsible health choices. The goal of the "Better Health: It's About Time!" initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. The initiative specifically targets infant mortality, prenatal care, adolescent pregnancy, cardiovascular disease, obesity, and diabetes, and also aims to eliminate racial and ethnic health disparities in these areas. The Department of Health is working on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intra-governmental strategies to collaborate with other departments in state government. The Department is also forming new partnerships with non-governmental agencies, community-based organizations and the faith community. The Department of Health and all sections, including maternal and child health, are involved in the development of new strategic plans for programs and activities.
/2009/ Commissioner Cooper has continued the Governor's emphasis on physical fitness and diabetes. She brought the two programs: GetFitTN and Project Diabetes to the Department of Health. (see the overview section.//2009//.
/2009/ Tennessee General Assembly passed legislation to increase the state cigarette tax and the law went into effect July 1, 2007. With the leadership and support of the Commissioner of Health and assistance from CDC, the Tobacco Use Prevention and Control Program (TUPCP) prepared a budget improvement request for a Comprehensive state Tobacco Cessation Initiative to be implemented in FY 07-08. The Commissioner presented the request to the Governor during the department's budget hearing. The allocation to the Department was $10,000,000; $500,000 is to be used to sustain and enhance Quitline systems and services and promotion, $1 million for youth initiation prevention, $1 million for community tobacco prevention programs and $6 million for NRT distribution thru local health departments. The TUPCP launched a QuitLine web page which is accessible from the Tennessee Department of Health's website and allows Department staff, community projects, internal and external partners to freely print information on the services provided by the QuitLine, access promotional print materials and best practice strategies for offering services and treating tobacco use and dependency. TUPCP/TDH secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows medical center journals, health system web reports, press releases, national, state and local news papers and health professional publication.//2009//.
Detailed discussion of the national and state performance measures is included in parts C and D of this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	209	176	180	164	204
Denominator	209	176	180	164	204
Data Source					Tennessee New Born Screening Data system
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data source is the state of Tennessee New Born Screening data system.

Notes - 2007
Data source is the state of Tennessee New Born Screening data system.

Notes - 2006
Data source is the state of Tennessee New Born Screening data system.

a. Last Year's Accomplishments
The state's Genetics and Newborn Screening (NBS) Program was established in 1968 as a result of state legislation requiring PKU screening of all babies. The NBS Program continues to utilize an established network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages also exist between the Centers and Children's Special Services for referrals. An advisory committee guides program activities and recommends changes; this committee has been vital in expanding the screening panel. Genetics staff, located at the State Laboratory, are responsible for interfacing with the State Laboratory to identify, locate and follow up on newborns who have unsatisfactory or abnormal results from the mandated screening. Referrals are made to the genetics and sickle cell centers as well as pediatric endocrinologists and pulmonologists. When an infant is identified as having a questionable specimen, the follow-up nurses contact the provider so that another specimen can be collected and sent to the State Laboratory or another means of confirmatory test can be done. Access to genetic screening, diagnostic testing and counseling services is available at three regional comprehensive genetic centers, two satellite Genetic Centers, five pediatric endocrinologists, four Cystic Fibrosis Foundation Care Centers, two comprehensive sickle cell centers and two satellite sickle cell centers for individuals and families who have or who are at risk for genetic disorders. If needed, local health department nurses assist in locating an infant needing follow-up.

This performance measure has been successfully met for many years due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. As of April 2008, the State Laboratory was testing for all the diseases recommended by national organizations, including the March of Dimes. Based on recommendations from the Genetics Advisory Committee, the decision was made to begin screening for cystic fibrosis in FY 2008. A work group (Pediatric Pulmonologists, Genetics Advisory Committee (GAC) members, follow-up staff, and laboratory staff) developed Cystic Fibrosis follow up and referral protocols and procedures and assisted in updating the provider and parent materials. Effective April 1, the screening panel was expanded to include cystic fibrosis.

The NBS Program updated the information systems software in 2008; these included the Case Management System (CMS), the Laboratory Metabolic Screening Data System (MSDS) which allowed the laboratory to begin interfacing the newborn screening instruments to the data base; and the positive or unsatisfactory results transfer to the follow up case management system. All reporting and follow up protocols were updated.

The State Laboratory has continually monitored testing cut-off values to determine if changes need to be made based on the population of Tennesseans. The data collected are reviewed by the Genetics Advisory Committee (GAC) which includes the Genetic Centers Directors, Pediatric Endocrinologist, and others.

A newborn screening DVD continues to be dispersed to stakeholders in order to educate them about newborn screening testing, proper specimen collection and follow up protocols for abnormal and unsatisfactory results and referrals. Continuing education credits will be offered through the National Laboratory Training Network (NLTN) until September 2009 for nurses and lab technologists that take advantage of the training. Program information is found at health.state.tn.us/NBS/index.htm

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen all infants born in Tennessee for those diseases/metabolites determined by the Genetics Advisory Committee and the Department and state law.			X	
2. Follow-up on all infants needing a repeat test or further diagnostic work.	X	X		
3. Work closely with Genetic and Sickle Cell Centers on follow-up and treatment.	X	X		
4. Work closely with birthing facilities on improving the unsatisfactory rates, including distribution of the revised training CD, routine calls, and site visits.	X			X
5. Support the Genetics Advisory Committee.			X	X
6. Work closely with all birthing facilities and health care providers on newborn screening testing and results.	X			X
7. Provide educational materials for parents and providers on newborn screening tests.	X		X	
8. Assist with re-evaluation of cut-off values for testing.			X	
9.				
10.				

b. Current Activities

NBS Follow-up provides quarterly reports to all hospitals submitting specimens, listing the number of specimens submitted and the number unsatisfactory. Hospitals utilize these reports for quality improvement and staff in-service training.

The GAC (members from the genetic centers, pediatric endocrinologists, hematologist, pediatrician/lawyer) met twice to guide the program and recommend changes in tests and procedures. There were many conference calls to discuss recommendations for NICU follow-up protocols. The make-up of the Committee was reviewed and it was determined that additional members with additional expertise are needed. At this time, nominations are being gathered and sent to the Commissioner in order to appoint additional at large member with the following areas of expertise: Neonatology, Pulmonology, and a parent of child with hearing loss.

NBS Follow-up continues to provide both parent and provider information on all the different metabolites and disorders. The new software updates allowed the program to go paperless in January 2009. All case management is documented, stored and backed up in the computer system eliminating extensive paper records storage. The website has been updated and contains extensive information for health professionals and parents. A prenatal newborn screening fact

sheet has been developed and distributed to hospitals and health departments to use in prenatal classes. Follow-up staffs are available to both providers and families.

c. Plan for the Coming Year
All previously described testing and follow-up services will continue. Education of health care providers will continue. Plans are to conduct onsite visits to tertiary centers during the next year.

Staff have researched potential recommendations on rescreening of very low birth weight babies in order to establish guidelines for collection and repeat collections for NICU infants. Survivability has continued to improve for increasingly smaller and more premature infants. NICU infants are at greater risk for missed or incomplete newborn screening due to focusing on the critical activities on their need for intensive care. The Perinatal Advisory Committee assisted with the development of guidelines for screening these infants. The next step is to develop a training program for NICU staff. During the next year, the NBS Follow-up Program will work toward completing the training and move to implementation of NICU Newborn Screening Guidelines.

Rules and regulations are being updated to include newly enacted legislation mandating newborn hearing screening and to define the role of the primary care provider in metabolic screening follow-up. New quality assurance efforts are underway in order to assess timely specimen transport and arrival in the lab for testing.

The Genetics Advisory Committee will meet at least twice during the year to address ongoing newborn screening issues, advise the Department of Health on the direction of the screening and follow-up program, and provide recommendations for changes to the screening panel.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	96	70	62	62	62
Annual Indicator	59.3	59.3	60.0	60.7	60.7
Numerator	3703	3703	3807	3381	3522
Denominator	6244	6244	6349	5570	5802
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	62	62	62	62

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Children's Special Services (CSS) continued to work to ensure that children and parents become active participants in all levels of decision-making. CSS collaborated with Family Voices to conduct surveys of families with children with special health care needs. The survey questioned the family involvement in the decision making process and the level of satisfaction with the services received. The results of the survey indicated that 92% of the respondents are involved in decision-making and 89% are satisfied with the level of services received. CSS and Family Voices also conducted town hall meetings and focus groups to discuss results of the surveys with families, providers, and community agencies. From these meetings, it was determined that families are still somewhat uncomfortable discussing their children's medical condition with health care providers. CSS recruited a parent specialist to serve in an advisory capacity to the CSS Advisory Committee. This individual provided valuable input to the physicians on this committee regarding the needs of family participation in medical decision for their children. This parent also served as a liaison to families as they sought to navigate the health care system. The CSS statewide Resource Directory was developed and disseminated to all local and metro health departments. This directory provides community resources by county and region and helps the families identify resources for their specific needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with groups who advocate and serve children and youth with special health care needs		X	X	
2. Have parents help develop the child's family services plan for each child enrolled in CSS.		X		
3. Include parents on the CSS Advisory Board.				X
4. Conduct annual parent satisfaction survey.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSS and Family Voices are in the process of developing a second statewide survey for children and youth with special health care needs. The survey will follow the CSHCN SLAITS model and will be conducted by phone. The results of this survey will be utilized as a guide for program staff to determine areas of focus or concern for CYSHCN. CSS program staff continues to educate families on interaction with medical providers concerning decision making for medical care while making a concerted effort to ensure satisfaction is achieved in each level of the process. CSS

participants and their families continue to participate in the development of a Family Support Plan (FSP). This plan is an assessment tool from which a problem/needs list is identified and goals and objectives are developed to address those problems/needs. The FSP includes medical and non-medical assessments including an individual plan of care and the identification of community resources. CSS Care Coordinators continue to offer education and assistance to families and participants on interaction with health care providers and integrated system navigation.

c. Plan for the Coming Year

CSS will continue to develop and strenghten partnerships with the Governor's Office of Children's Care Coordination (GOCCC), Family Voices, Early Childhood Comprehensive Systems (ECCS) and other child health policy makers to collaborate with local, state and federal agencies to develop a medical home for all children in the State of Tennessee, which includes the special health care needs population.

Care Coordination standards will be developed to ensure all families receive education and training on interaction with medical providers concerning their involvement in making decisions for medical care that will maximize the potential for satisfaction.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	96	75	63	64	65
Annual Indicator	60.0	60.0	60.7	52.7	52.7
Numerator	3746	3746	3857	2935	3058
Denominator	6244	6244	6349	5570	5802
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2008

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CUBE data system reports were monitored to ensure that all CSS eligible participants received services within the medical home. Program staff continued to update and educate local primary care providers concerning the necessity of the medical home as well as other local resources available. All program policies were evaluated to make certain that coordinated ongoing comprehensive care within the medical home was available to all participants. On-site monitoring of all CSS metro and regional offices was conducted to ensure program compliance with policies and procedures. CSS conducted a statewide face-to-face meeting with program staff for policy and procedure update and transitional services development.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination services to each enrolled child and his/her family.	X	X		
2. Assist families moving from or to other states and needing CYSHCN.		X		
3. Use the monitoring system to identify each child's medical home or the need for one.	X			X
4. Continue to educate local primary care providers on the medical home concept.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Governor's Children's Cabinet, the Tennessee Council on Developmental Disabilities, the Tennessee Disability Coalition, Family Voices, and Child Health Policymakers continue to be important partners. This partnership includes regularly scheduled meetings as well as participation in the CSS annual meeting to discuss CYSHCN needs for accessing services, prioritizing needs, and presenting them to policymakers to help determine legislative action.

CSS program staff continues to assist families in the identification of pediatric/family practitioners or specialists to provide coordinated ongoing comprehensive care within the medical home. Participants and families with children age 14-21 years of age are provided information and instructions that assist them in transitioning from the pediatric or adolescent medical home to an adult provider.

c. Plan for the Coming Year
The CSS Family Service Plan (FSP) will be revised to include a comprehensive transition plan for all CSS participants age 14-21 years old. The revision of the plan will help families to identify and develop a medical home transitional process from pediatric providers to adolescent and adult providers. CSS staff will continue collaborating with GOCCC, ECCS, Family Voices and others to ensure that all children have ongoing comprehensive coordinated family centered culturally competent care in the child's county. CSS Care Coordinators will continue to assist the families to coordinate services between the primary, sub-specialty, and specialty providers in the

development of a medical home for all participants with special health care needs.

Based on results of on-site monitoring during the previous year (2008), policies and procedures are being updated and developed to ensure all aspects of the medical home in included in the individualized transition plan.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	96	75	64	64	69
Annual Indicator	62.0	62.0	61.4	67.7	67.7
Numerator	3871	3871	3897	3771	3928
Denominator	6244	6244	6349	5570	5802
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	69	70	70	70

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSS continued to update and educate families and providers concerning the latest insurance information available including TennCare coverage and Cover TN insurance programs.
CSS experienced an increase in the number of children served; this increase in enrollees forced CSS to become more involved in the direct medical care of the children served. Fiscally it appeared more beneficial for CSS to direct its own medical clinics rather than have each eligible child separately visit a medical specialist, but current health department infrastructure does not include this option.

CSS continued to educate families and providers concerning medical insurance information while continuing to require application for TennCare and other SCHIP benefits. Due to disenrollment of

participants from TennCare and State Statute providing for coverage of cystic fibrosis participants until their demise, CSS provided benefits for 35 individuals over 21 years of age who have cystic fibrosis and limited or no medical insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that all children applying for CSS services also apply for TennCare or Cover TN products.		X		
2. Provide care coordination services to all CSS families statewide assisting families with access to medical care, utilization of services, transportation, etc.		X		
3. Work with TennCare, the managed care organizations, and providers to ensure service needs are met of this special population.		X		
4. Assist families with any needed appeals to TennCare for denied services		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS expected an increase in the number of children being served due to budgetary constraints that prevents TennCare from expanding their medically needy enrollees. CSS is in collaboration with SCHIP to develop mechanisms that will provide families the information and assistance they need to understand program requirements and application for benefits. CSS staff was trained on all the SCHIP products, and continue providing this information to participants and families. CSS continues to provide medical services as well as care coordination and works with families educating them on all available public and private insurance options.

c. Plan for the Coming Year

CSS will be partnering with TennCare managed care organizations (MCOs) to ensure insurance is available to all eligible constituents by establishing a referral system the will allow participants with special health care needs to be referred to local MCO providers by CSS, or MCOs to refer participants to CSS for eligible medical services.

CSS will continue marketing and outreach activities that include contacting all child-serving agencies to provide information regarding CSS Services, TennCare and SCHIP in their informational brochures that are provided to families receiving services from those agencies.

CSS will be displaying program information electronically in the local human services offices, which will include program eligibility requirements, and information regarding other government sponsored insurance programs. CSS will provide narrative and electronic information for inclusion in the MCO newsletters and other printed resource material.

CSS will continue providing medical services to those individuals who meet program eligibility requirements.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	96	90	82	82	93
Annual Indicator	80.0	80.0	80.8	91.8	91.8
Numerator	4995	4995	5128	5113	5326
Denominator	6244	6244	6349	5570	5802
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	93	93	93	93	93

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSS continued to identify needed services available within the community that are easily accessible. Staff worked closely with MCOs, insurance companies, and other providers for improving access to local services. Patient satisfaction surveys were conducted during regular clinic visits. In addition, CSS continued to collaborate with agencies to facilitate referral and access to CSS and partner agencies' services. CSS developed and disseminated a statewide resource directory with available resources in all 95 counties that was utilized to identify community resources and make referrals to families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate CSS services with other health department services (i.e. scheduling access, etc.)		X		

2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.		X		
3. Work with regional and local health councils to identify needs and gaps in services in specific communities.				X
4. Work with state agencies such as the Department of Mental Health/Developmental Disabilities, Education, and Mental Retardation, local mental health centers, and school systems to develop a system of care approach to services for the population.				X
5. Conduct annual parent satisfaction surveys.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSS continues to intensify their efforts with the TN Council on Developmental Disability, Tennessee Disability Pathfinder, Tennessee Technical Assistance & Resources for Enhancing Deafblind Supports (TREDS), Tennessee Early Intervention Systems (TEIS), Tennessee Housing and Development Agency (THDA), United Cerebral Palsy (UCP), Tennessee Department of Labor and the Governor's Office of Children's Care Coordination in an effort to provide CSS participants with all eligible services and resources.

c. Plan for the Coming Year
CSS will continue to update and disseminate the statewide resource directory, which allows care coordinators and families to access community based resources at the local county level. CSS will continue to update this directory bi-annually and will ensure that all known local/community based resources that are available will be included.

CSS marketing and outreach campaign will further identify available resources and CSS eligible families will be notified of new resources during their FSP review.

CSS will continue working with partner agencies to develop a system of service that is organized for easy access and use.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	96	50	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1561	1561	1561	1534	1245
Denominator	1561	1561	1561	1534	1245
Data Source					CSHCN Survey
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data source is the National CSHCN Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSS was involved in transitional training that was provided by Healthy Ready to Work. This training allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans. CSS collaborated with the Department of Education, the Department of Mental Health and Mental Retardation, the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force that worked on developing transition plans for all children.

CSS worked to identify each and every need a participant and their family will have concerning transition from adolescence to adulthood. CSS worked on the development of a statewide and regional transitional team and continues in the identification of transitional resources within the community. A resource guide to transitions was developed and shared with other agencies, private providers, advocacy groups, families, and other entities interested in transitions to adulthood.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include transition services in the individual care plans for those clients approaching adulthood.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all approperiate referrals for those clients.		X		
4. Train CSS staff on transition issues.		X		
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

CSS is continuing the development of a statewide transitional team and plans that can be utilized in the regional and metro areas. The team will be comprised of parents of children with special health care needs, CSS participants, staff and community agency representatives. Care Coordination standards are being established to standardize and enhance transitional services for the CSS participants. Field staff is being provided technical assistance based on the training received from Healthy Ready to Work. Age appropriate transitional plans will continue to be developed for all participants age 14 and older. A Medical History Summary Form has been developed and will be provided to all CSS participants age 14-21 as a concise medical history that can be provided to medical providers as the participants transition from pediatric medical homes to adult medical homes. The Medical History Summary Form will also be made available to any CSS participant that reaches maximum treatment or terminates from the CSS program.

c. Plan for the Coming Year

CSS will continue to collaborate with Tennessee Department of Education, Tennessee Department of Mental Health and Mental Retardation, Juvenile Justice, Labor and Workforce, Children's Services and representatives from other child serving agencies on the Youth Transition Task Force that addresses all transition services necessary to transition from youth to adults. CSS will continue working with Tennessee Department of Education to include a medical home transition component in the Department of Education transition guidelines. CSS will continue collaborating with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans. All CSS participants age 14-21 will have an individualized transition plan that includes components relative to medical home, independent living, higher education, employment and recreation.

Healthy Ready To Work will continue to provide technical assistance in the development of transition plans.

CSS will collaborate with the American Academy of Pediatrics to develop emergency preparedness guidelines for children and youth with special health care needs that will become part of the individualized transition plan.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	94	95	81	83	88
Annual Indicator	77.2	79.1	86.7	86.7	81.2
Numerator	60040	90761	1300	1300	220
Denominator	77773	114731	1500	1500	271
Data Source					NIS survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	88	89	89	89

Notes - 2008
Data source is the NIS regarding Tennessee participant. Survey data size for Tennessee is small (271)
2008 survey data is not available but used 2007 data as provisional data.
The reduction in survey sample size caused the numerator and denominator to be under the 300 range.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2006 and the CDC Immunization survey and is based on survey sample size for this performance measure.

Notes - 2006
Data is from cdc.gov/nipcoverage/nis/05-06.
This data is from the cdc immunization survey and is base on survey sample size.
In 2005 full schedule of appropriate immunization was expanded.

a. Last Year's Accomplishments
Tennessee measures immunization at age 24 months through its annual immunization survey. The survey is a statistically valid sample of the immunization status of two-year-old children that is statistically valid for each of the state's administrative regions. The 2008 survey comprised 1487 children. The completion rate for the standard 4:3:1:3:3:1 Series defined by the Centers for Disease Control and Prevention in that survey was 82.3%. All health department staff have been trained to review the immunization status of any person presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the primary care provider. The racial disparity between black and white children that was statistically significant in 2007 had narrowed and was not statistically significant in 2008; however there is a pronounced racial disparity in the use of influenza vaccine (coverage among black children was half that among white children surveyed). While use of influenza vaccine increased overall, there were wide regional variations in coverage (from <10% in one region to >50% in another). Beginning in 2007, the Immunization Program has shared its findings with TennCare and with the state chapters of the American Academy of Pediatrics and the Academy of Family Physicians. Since the 2007 survey, the Immunization Program has published the results of its survey of 24-month-old children on its web page.

Before 2007, efforts to communicate this information were limited. The increase in awareness and educational activities around racial disparity has contributed to improvements and is expected to help narrow the gap in influenza vaccine coverage in the future.

The Department's contractual arrangement with TennCare to provide EPSDT exams has provided additional opportunities to provide immunizations and to check current status. The immunization coverage rates for day care children who are in compliance with the immunization law was up from 92.8% in 2006-7 school year to 94.4% in the 2007-8 school year.

Influenza vaccination was first assessed in the state's 2007 annual survey of immunization coverage among 24-month-old children, so the awareness of this disparity is new. The Medical Director of the Immunization Program has highlighted this finding at state and national meetings, with public health field staff and through meetings with representatives of vaccine manufacturers who visit provider offices regularly. The Immunization Program also receives grant funds from CDC to promote influenza immunization; it uses this funding to support site visits to healthcare providers by public health field staff who highlight these findings and educate providers about the

CDC recommendation to provide influenza vaccine to all children under age 19 years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunization in local health department clinics.	X			
2. Check immunization status of persons requesting any type of services at local health department clinics.	X			
3. Maintain and continue to improve the Immunization Registry software and capacity for electronic access for submission and retrieval of data.			X	X
4. Use intranet connection to increase data input by private physicians to Immunization Registry.			X	X
5. Access immunization coverage levels in the population.				X
6. Immunization staff continues to work with providers within their geographic areas providing technical assistance.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include: (1) identifying high-risk children and assure they are completing their immunization series; (2) performing formal assessments during site visits (known as "VFC/AFIX visits") to all providers enrolled in the VFC program to ensure efficient service delivery of vaccines to those for whom they are recommended; (3) expanding the availability of the immunization registry web site in private physicians offices; (4) conducting immunization level assessments in population sub groups such as day care enrollees, identifying those at high risk of not completing immunizations and devising strategies to reach them; and (5) conducting follow-up on children born to hepatitis B infected women to ensure receipt of HBIG and hepatitis B vaccine as recommended.

c. Plan for the Coming Year

The strategy will be much the same as this year. The major emphasis will be on the VFC/AFIX visits to the providers' offices to assure appropriate adequate use of vaccines. There will also be an emphasis on expanding the availability of the immunization registry web site and a new objective will be to increase the amount of private physician-administered vaccine doses that are reported to the immunization registry. Immunization level assessment activities will continue as well as the development of approaches to reach those less likely to complete immunizations on time. Follow-up of children born to hepatitis B infected women will also continue.

$4.4 million from the recovery funds has been received to provide additional vaccines through health departments. These funds will be used for both children and adults. There will be a time-limited adult vaccination campaign primarily promoting tetanus-diptheria-pertussis (Tdap) and pneumococcal polysacharride vaccines. For children, this will help fund the surge of children and teens ineligible for the Vaccines for Children Program who are expected to visit health departments in mid-2010 when new state school immunization requirements take effect. Most of these children have high insurance deductibles or co-pays for vaccination services.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	24	23	27	26.5	26.5
Annual Indicator	26.3	27.5	28.6	27.8	27.3
Numerator	3057	3229	3392	3361	3327
Denominator	116426	117523	118599	120852	122020
Data Source					Tennessee Health Statistics system
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	25	25	25	25

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2008 population estimates and the 2008 Tennessee Birth Master file (Tennessee residents only) for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Birth Master file for this performance measure.

Notes - 2006
Data is from Tennessee Birth Master files.
Data source is the State of Tennessee Health Statistics System.
The increase of 1.2 appears to be a trend that might happen in the U.S. (most states) and consistent with previous years.

a. Last Year's Accomplishments
CY 2008 data from the Family Planning Annual Report show that the program served 35,808 clients ages 19 and under--a decrease of 997 from CY 2007 (due to the loss of one provider agency). Notwithstanding a slight decrease in teen pregnancy rates, the loss of family planning service capacity raises concern that the rate decrease can be maintained. The state is providing EPSDT visits for children and adolescents in the local health departments, under contract with TennCare. During fiscal year 2008, the health department clinics performed 58,428 EPSDT screenings, of which 8,751 were to adolescents ages 12-20. These exams include assessment regarding sexual activity and referral for family planning services when needed.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community. Each council participates in a wide range of activities, depending on local priorities and resources. Networking to provide community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, health fairs, and media presentations is a TAPPP priority. Data for CY 2008 showed that statewide staff

provided family life education programs to over 67,000 students; almost 19,000 adults; and worked with 13,000 parents and professionals.

The Department of Health did not conduct a Title V, Section 510 Abstinence Education Program for FY 2007. Congress limited funding to the first quarter of FY 2007, renewed funding for the next quarter, and again for the remaining 6-months of FY 2007. Because the funding pattern would not allow for long-term planning and contracting with community-based abstinence projects, Tennessee did not participate in the Federal Title V Abstinence Education Program in FY 2007. The former Abstinence Education Program Director now directs the Adolescent and Young Adult Health and Asthma Programs.

The Adolescent and Young Adult Health Program Director collaborated with the National Center for Youth Issues to coordinate the annual, statewide Celebrating with Healthy Choices for Youth Conference. Three hundred and forty-two public health staff, educators, counselors, youth service workers, and members of the faith based community attended. The conference provided current best practices for various youth and family health concerns and overall youth development. Additionally, the conference provided opportunities to network with others in the youth service/education fields.

The Community Prevention Initiative was transferred to the Department of Mental Health, Division of Alcohol and Drug Abuse Services, on October 1, 2008.

The Adolescent Health Advisory Committee is a collaborative of representatives from Maternal and Child Health, TENNderCare, the Division of Minority Health and Disparity Elimination, the Division of Alcohol and Drug Abuse Services, the Governor's Office of Children's Care Coordination, the Division of Special Populations, the Division of Clinical Leadership, and regional health department staff. Members are selected based on their expertise in one or more areas of youth health care, well-being and development. During FY 07-08, the Committee met quarterly and discussed best practice strategies to meet Healthy People 2010 health objectives for adolescents. Educational activities and advocacy for obesity prevention, nutrition and exercise counseling, and asset development were among the pertinent health issues addressed. The online Adolescent and Young Adult Health in Tennessee Report is updated bi-annually as the data become available.

Additional data information on adolescent pregnancies is included in the section on plans for the coming year due to space limitations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family planning services in all 95 counties.	X			
2. Provide education in community settings related to adolescent health and prevention of risk taking behaviors.				X
3. Continue TAPP coordinators activities and coalitions.				X
4. Emphasize services for adolescents, including direct services, care coordination and referral.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the first half of FY09, 8,245 adolescents ages 19 and under were provided services through the statewide Family Planning Program, with services at 131 sites in all 95 counties. The Tennessee Adolescent Pregnancy Prevention Program (TAPPP) utilizes county and regional level health educators to provide community education. In the first half of FY09 educational services have been provided to 18,092 adolescents and children and 8,998 adults; 2,225 parents have been reached through specific parent education sessions; and consultation, training, or technical assistance was provided to 3,972 professionals. The number of educational contacts with adults, professionals, and parents remains consistent with last year's numbers. Presentations and consultations cover a variety of issues and topics such as community awareness of teen pregnancy, health department services, sexuality education curricula review and revision, teacher training on health issues and curricula, abstinence education, parenting concerns, and adolescent/child growth and development. The National Day to Prevent Teen Pregnancy (May 6, 2009) has been a popular focal point for prevention messages. The primary event is teens gathering to take an online quiz about sexual risk taking and consequences. The Adolescent Health Advisory Committee continues to meet quarterly and includes speakers on disparities in health care through improving cultural proficiency, mental health, and youth development.

c. Plan for the Coming Year

MCH programs will continue to offer clinical and educational services to the adolescent population and offer support, technical assistance, and training to community agencies and other groups working towards lowering the teen pregnancy and birth rates. All current year activities will continue.

Congress has appropriated funds for a new 5-year grant cycle from FY 2009 -- FY 2013; thus Tennessee will again take part in the federal Abstinence Education Program and has been awarded funding for FY 2009. Funding for the remaining four years is contingent on availability. Community based agencies will be identified to conduct the abstinence until marriage/youth development programming in their respective communities. Agencies must provide a minimum of 7 hours of classroom instructional training related to abstinence and relationships. Additionally, agencies must provide at least one additional activity known to develop healthy, well-balanced youth, and aligned with the Tennessee Department of Health's objective to reduce obesity rates among its citizens such as sports or nutrition counseling.

Tennessee's overall adolescent pregnancy rate for ages 10-17 has inched up from a 2004 low of 13.2 to 13.9 in 2007. There were 3,524 live births and 871 abortions and fetal deaths, for a total of 4,395 pregnancies to this age group, accounting for 4.3 percent of all Tennessee pregnancies in 2007. With a rate of 34.3, Tennessee has exceeded the Healthy People 2010 target adolescent pregnancy rate of 46 per 1,000 females for the 15-17 age group. The pregnancy rates for black adolescents continue to be higher than that of white adolescents in all age groups: 24.5 for 10-17 year-olds (10.9 white); 62.6 for 15-17 year-olds (26.9 white); and 2.9 for 10-14 year-olds (0.9 white).

There were 3,524 births to females ages 10 through 17, accounting for 4.1 percent of all Tennessee births in 2007. The birth rate for this age group was 11.1 live births per 1,000 women. For 2006, the birth rate for mothers 10-17 was also 11.1 live births per 1,000 women. The 2007 birth rate for the 15-17 age group was 27.8. It remains to be seen in coming years if Tennessee will follow the national trend of increasing teen births.

As with the pregnancy rate, the birth rate disparity gap between black and white persists: The 2007 rate for 10-17 year old black females is 18.4, and that for whites is 9.2, although these numbers reflect a slight decrease from previous years.

Of the 3,524 births to Tennessee adolescents in 2007, 91.7 percent were out-of-wedlock, 9.4 percent of the mothers had had at least one other birth, and 13.4 percent had had another pregnancy. It is this last group that the program targets with outreach and education efforts concerning birth spacing.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	17	25	23	23	24
Annual Indicator	22.0	21.9	22.3	21.8	37.2
Numerator	35059	71961	75789	3769	366
Denominator	159359	329279	339485	17256	983
Data Source					Tennessee Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	40	40

Notes - 2008
Data source is the 2008 Tennessee Oral Health Survey of children ages 5 - 11 years.

Notes - 2007
Thses data are from the Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

Notes - 2006
This data is from the of Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

a. Last Year's Accomplishments
The School Based Dental Prevention Program (SBDPP) is a statewide, comprehensive dental prevention program for children in grades K-8 in schools with 50% or more free and reduced lunch. It consists of three parts: dental screening and referral, dental health education, and application of sealants. During FY 08 (July 1, 2007-June 30, 2008), school based dental prevention services were being delivered in all 13 regions. Data for FY 08 show that 137,888 children had dental screenings in 333 schools. Of these, 34,719 children were referred for unmet dental needs. Full dental exams were conducted on 69,377 children. A total number of 306,207 teeth were sealed on 54,629 children. 179,403 children received oral health education programs at their schools by a public health dental hygienist. Dental outreach activities include provision of informational material for TennCare enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need.

Fixed and Mobile Dental Program: The Tennessee Department of Health has 54 fixed dental clinics located in 53 rural counties. The scope of services includes comprehensive dental care to children and emergency dental care for adults. During FY 08, more than 21,000 children and more than 3,500 adults were treated in TDH dental clinics. The TDH operates three mobile dental clinics providing comprehensive dental services to underserved children at school sites. During FY 08, 224 children received more than $82,000 worth of dental services in TDH mobile dental clinics.

Cavity Free In Tennessee - Early Childhood Caries (ECC) Prevention Program targets regular Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) visits with children at risk for ECC. In the first year of life, a child may visit a health care professional as many as six times as a part of EPSDT. Nurses and nurse practitioners can deliver preventive oral health services to children during these visits, as well as educate their parents or caregivers about keeping children's teeth healthy. These visits provide an opportunity for children to receive dental screenings, the application of fluoride varnish, and early dental referrals. Because many children do not access dental care until there is a need or until school-age, this program now allows many children to receive a preventive service they might not have otherwise received.

Children will continue to be referred to their dental provider for regularly scheduled visits for dental services or at any sign of need such as decay, eruption abnormalities, prolonged nonnutritive sucking, and other oral health concerns. While children, birth to 5 years old, are the target population for Cavity Free In Tennessee (CFIT), this program is available for children and teens in all seven rural regions of Tennessee. Currently all the rural regions are providing these expanded dental preventive services. From July 1, 2007-June 30, 2008 approximately 11,000 at risk children have been screened, referred, and had fluoride varnish applied in Tennessee Department of Health medical clinics by nursing staff.

Statewide Oral Health Survey: In the fall of 2008, the TDH, Oral Health Services Section conducted a statewide oral health survey of a sample of children ages 5-11 years, representing approximately 551,000 Tennessee children in this age group. The survey goals were to establish age-specific data for the prevalence of dental caries, sealants, dental injuries, estimates of treatment needs and to describe variations according to age, sex, race, and socioeconomic status. Oral Health Services plans to conduct this type of survey every 5 years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide clinical dental services to TennCare children.	X			
2. Provide preventive dental services including sealants and oral health education to children in schools.	X	X	X	
3. Provide dental outreach activities.		X	X	
4. Provide dental services using the three mobile units in Northeast, Mid-Cumberland and West Tennessee Regions.	X	X		
5. Continue the fluoride varnish program.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All services described in the previous section continue in the current year with the exception of the Oral Health Survey which will occur every five years.

c. Plan for the Coming Year
Data from the statewide survey of elementary aged school children will be used to facilitate planning and program development during the upcoming year. All direct services and education services described in
the above section will continue.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3	3	3	2.5	2.5
Annual Indicator	4.2	4.0	5.4	3.9	3.0
Numerator	50	48	65	47	36
Denominator	1196148	1204737	1210629	1194718	1201009
Data Source					Tennessee Health Statistics system
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2	2	2	2	2

Notes - 2008
The data reported in 2008 are population estimates for 2008 (Tennessee resident only) and the Tennessee Death Master file for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Death Master file for this performance measure.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2006 population estimates and the Tennessee Death Master file for this performance measure.

a. Last Year's Accomplishments
Injury Related Deaths Among Children: The state's rate of death from motor vehicle crashes for children ages 14 and younger has been on the decline since 1994. In 2007, 11% or 120 of all child fatalities were from motor vehicular incidents (rate = 8.3 per 100,000). This is a slight

decrease from 126 reported in 2006. From the 2007 child fatalities resulting from motor vehicles, 47 (39.16% of all childhood fatalities due to injuries resulting from vehicular accidents) were 14 and younger. Of the 47 deaths: 36 were white; 9 black and 2 other. The Child Fatality Review teams completed a review of 112 children that died in vehicle related incidents.

See Me Safe, developed by Ford Motor Company Fund, the philanthropic arm of Ford Motor Company, in partnership with Meharry Medical College, shows families how to keep their children safe by providing them hands-on instruction from CPS-certified technicians on the proper installation of their car seats. The program addresses some common issues, such as how to properly strap the seat into a vehicle, and explains the correct age, weight, and height requirements for each type of seat. See Me Safe will partner with Matthew Walker Comprehensive Health Center for its Nashville child passenger safety seat efforts.

Public Chapter 481 - In 2007 legislation passed requiring a helmet for operators and passengers 18 or younger when operating off-highway motor vehicles; parents will receive fines for noncompliance up to $50 and $10 in court costs.

The exemptions from helmet law which would exempt driver or passenger who is 21 years of age and older from requirement that persons riding a motorcycle must wear a helmet failed in the House Transportation Public Safety Subcommittee leaving the current law intact.

The Governor's Highway Safety Office (GHSO) advocates for highway safety by working in conjunction with law enforcement, judicial personnel and community advocates to coordinate activities and initiatives relating to the human behavioral aspects of highway safety. Their mission is to develop, execute and evaluate programs to reduce the number of fatalities, injuries and related economic losses resulting from traffic crashes on Tennessee's roadways. The GHSO is responsible for working with the National Highway Safety Administration to implement programs focusing on occupant protection, impaired driving, speed enforcement, truck and school bus safety, pedestrian and bicycle safety and crash data collection and analysis. Programs administered by the Governor's Highway Safety Office are 100% federally funded. In the last three years, the GHSO has gone from no programs for teen drivers to several including partnerships with the Tennessee Secondary School Athletic Association (the governing body for high school sports in Tennessee), entertainment groups to complete games shows and other fun but educational programs, the Lead and Live program for teen leaders, and the Blake McMeans documentary (about a young man who was paralyzed after a drunk-driving accident).

A Strategic Highway Safety Plan was created to reduce the fatality rate by 10% by the end of CY 2008, based on CY 2002 data. It is projected this will result in saving 127 lives in CY 2008. The plan's on-going efforts are to define a system, organization, and process for managing the attributes of the road, the driver, and the vehicle to achieve the highest level of highway safety by integrating the work of disciplines and agencies involved.

The Nutrition and Wellness Division of the TN Department of Health oversees the Child Safety Fund Program. Funding for the program is collected from the fines levied to motorists who are in violation of the Tennessee child passenger restraint law. Governmental or nonprofit organizations are eligible to obtain the funds to provide services to children, 0-8 years old, in low income families that meet federal poverty guidelines.

The Help Us Grow Successfully (HUGS) home visitation program includes education and outreach information in the curriculum for families advising and reminding them about vehicle safety devices as they pertain to children 0-5 years. In FY 2006-07 more than 7900 families in 89 of the 95 counties were served.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate health department staff and the general public about the child safety law.			X	
2. Provide child safety seat checks at selected local health departments and other community sites.	X			
3. Conduct injury control activities on seatbelts and child safety seat usage.			X	
4. Partner with local law enforcement agencies, Safe Kids Coalition, Head Start Centers, school systems, and Governor's Highway Safety Office.				X
5. Provide education to students, train providers, participate in exhibits and health fairs, etc. as required.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As a direct result from a recommendation made by the Child Fatality Review program, HB 107 -- SB 393 was signed into law on May 13, 2009 with an effective date of July 1, 2009; this new law makes it a Class C misdemeanor for the offense of transmitting or reading written messages (text messaging) on a hand held mobile telephone or a personal digital assistant while operating a motor vehicle on any highway.

Statewide Traffic Safety programs for this year include "Ollie the Otter" who has been to 251 schools and has been seen by at least 75,000 students. "Ollie the Otter" has been into at least 4,200 classrooms with his booster Seat Program. "Tenny C. Bear" started in November 2008. This safety program covers all fazes of Traffic Safety. "Tenny C. Bear" has become so popular the Traffic Safety office is in the process of getting three more Bears to assist with this training statewide.

From July 2008 to March 2009, the Child Safety Seat Fund has received $189,234.38, in funds, expended $151,913.56 and purchased 3,184 child safety seats. Of the seats purchased 2,353 have been distributed.

The Healthy Start home visitation program has served 1,309 families and 1,563 children using the Florida Home Visitation curriculum which includes education and prevention outreach information on child safety seats and restraints.

c. Plan for the Coming Year

The Department of Health, the Departments of Transportation and Safety and our partners will continue efforts to reduce the number of deaths and preventable injuries among children and adults due to lack of proper restraints.

The Strategic Highway Safety Plan -- Performance Plan FY 08-09 identifies decreasing the number of 15 to 34-year-old drivers and passengers killed or seriously injured in all traffic crashes by 5% as a goal.

The Injury Prevention and Control Program of the Department of Health will formulate an operational work plan in keeping with the program's goals, which are: To mobilize partnerships and engage individuals at multiple levels in activities which identify risk factors and promote a

reduction in unintentional injuries derived from unhealthy safety practices: 1) To promote the development and implementation of initiatives and services promoting injury prevention and safety. 2) To provide technical support and training. 3) To work with communities and promote policy change. 4) To evaluate and improve programs.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	34	36
Annual Indicator		29.3	28.0	31.4	24.1
Numerator		440	420	14705	241
Denominator		1500	1500	46777	1000
Data Source					CDC/National immunization survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	30	30	30	30

Notes - 2008
Data source is the national Immunization survey. Tennessee 24.1 (+- 6.1)
Percent of 95 % confidence interval.
Source: CDC.gov/breastfeeding/data. The sample size appearing in the NIS breastfeeding table are sightly smaller than numbers published in other NIS publications. The sample was limited to records with valid response to the breastfeeding.
The reduction in survey sample size caused the numerator and denominator to be under the 300 and 1000 range.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the CDC Nutrition Surveilance file for this performance measure.

Notes - 2006
Data source is national Immunization survey. Source: CDC.gov/breastfeeding/data.
The numerator and denominator are based on estimates.

a. Last Year's Accomplishments
Breastfeeding is widely promoted through the WIC program and local health departments must establish and maintain an environment which supports and encourages women in the initiation and continuation of breastfeeding. Print and audio-visual materials in the clinic must be free of formula product names and formula stored out of the view of clients. Educational materials are to portray breastfeeding in a way that is culturally and aesthetically appropriate for the population served. Health departments must have a designated area for moms who prefer to breastfeed in a private place. In addition, each of the thirteen established nutrition centers has a room exclusively

for breastfeeding mothers to use.

Breastfeeding counseling is a required nutrition education component of the WIC Program and all pregnant women are encouraged to breastfeed, unless contraindicated for health reasons. Breastfeeding education is offered individually and in group settings. WIC serves over 21,000 pregnant women and enrolls approximately half of newborns in the state. Thirty percent of WIC delivered mothers are breastfeeding at time of postpartum certification. Presently, there are 7,646 breastfeeding mothers on the WIC program. WIC provides on-going breastfeeding information and counseling in the clinic, hospital, and home setting. Manual and electric pumps are issued to eligible mothers. Mothers who deliver prematurely or have a baby in the Neonatal Intensive Care Unit are given priority for hospital grade electric pumps.

Furthermore, HUGS (Help Us Grow Successfully) directors and home visitors attended regional workshops on breastfeeding in 2007. The 2-3 hour in-service covered the basic foundational principles every counselor must know to help mothers get off to a good start with breastfeeding and how to address problems early to help prevent mothers from weaning early. Combining breastfeeding education and support and HUGS home visits has potential to significantly increase breastfeeding rates.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding coordinators and advocates in every region work with health care providers, health department staff and postpartum women to assist and promote breastfeeding.	X	X		
2. Breastfeeding data are routinely collected on WIC clients.				X
3. USDA grant continues to be used to maintain an effective breastfeeding peer counselor program in selected counties.	X			X
4. Establish breastfeeding objectives in the Tennessee Obesity Prevention Plan.				X
5. Partner with the Tennessee Initiative for Perinatal Quality Care (TIPQC) on their breastfeeding initiative for 2010.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Tennessee has maintained funding the past 4 years for a breastfeeding peer counselor program. A peer counselor is a paraprofessional, ideally a current or previous WIC client, who has successfully breastfed and has a desire to help other mothers succeed with breastfeeding. By combining peer support with the on-going breastfeeding promotion efforts in the Tennessee WIC program, peer counselors have the potential to significantly impact breastfeeding rates among WIC participants, and, most significantly, increase the harder to achieve breastfeeding duration rates. The long-range vision is to institutionalize peer counseling as a core service in WIC. Breastfeeding rates increased in 15 of 18 counties receiving grant funds to hire a peer counselor.

c. Plan for the Coming Year

Plans for the coming year include maintaining the WIC breastfeeding peer counselor program, continuing to work with HUGS to strengthen breastfeeding support for mothers and their families, inclusion of a breastfeeding focus in the Tennessee Obesity Prevention Plan, and networking with

Tennessee Initiative for Perinatal Quality Care (TIPQC) on their breastfeeding initiative. The Tennessee Initiative for Perinatal Quality Care (TIPQC) funded by a grant from the Governor's Office of Children's Care Coordination (GOCCC) was officially launched in October 2008 with a goal of engaging providers across the perinatal spectrum in statewide, evidence-based and data-driven quality improvement projects. The obstetrical (OB) community had the opportunity to join together for the first time in a statewide collaborative at the March TIPQC meeting. The OB side of TIPQC will continue to organize under a committee of leaders throughout the state. At the meeting, they voted on their first state project, which will focus on a breastfeeding awareness campaign targeted at all pregnant woman.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.0	97.0	88.9	91.1	95.0
Numerator	77202	79010	80173	83570	86434
Denominator	79590	81454	90155	91754	90960
Data Source					2008 New Born Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	99	99

Notes - 2008
Data source is the 2008 newborn screening database and data includes births that are Tennessee residents and non Tennessee Residents.

Notes - 2007
Data source is the 2007 nenborn screening database and data includes births that are Tennessee residents and non residents.

Notes - 2006
Data source is the State vital records and Newborn screening registry.
No law requires hospitals in the state to report on screening.

a. Last Year's Accomplishments
The Newborn Hearing Screening Program reported 2007 data to the Centers for Disease Control and Prevention in February 2009. There were 92,049 occurrent (resident and non-resident) births reported by vital records. 83,576 (91%) infants received a hearing screen; of those infants, 99% were screened prior to one month of age. In 2007, 51 infants were diagnosed with permanent hearing loss; 40 had bilateral loss and 11 had unilateral loss. The expected incidence of hearing loss for Tennessee is 89-127 infants (National incidence 1:1000 to 3:1000). The number of follow-

up hearing tests reported by individual providers and audiologists continued to improve.

Tennessee passed legislation, known as "Claire's Law", that requires all hospitals to conduct hearing screening prior to discharge or before one month of age and requires insurance to reimburse for the screening. In addition, the mandate requires the Tennessee Department of Education, Early Intervention System (TEIS), to assist in follow-up of infants not passing the screen and those at risk for hearing loss. It became effective July 1, 2008. The Newborn Hearing Screening program initiated steps to implement the new legislation.

Prior to the mandate, all Tennessee hospitals provided universal hearing screenings; after the mandate there was improvement of efforts by hospitals and medical providers to report screening and follow-up testing. Hospitals are taking a more active role in identifying infants that did not have a screen or did not have the screen reported to the state program. Some hospitals took the initiative to collect and submit missing data on 2007 infants. "Claire's Law" was named after a child that did not have a hearing screen and was later determined to have hearing loss.

In August 2008, an expanded hearing follow-up data module was added to the Neometrics newborn metabolic and hearing screening data system. The new "Hearing Summary" module enabled the hearing program to eliminate entry of ear specific infant follow-up into an additional Access data system. This reduced personnel time for the dual entry. The program lost 1.0 FTE support staff position in August 2008 due to a statewide "buyout" program. Staff from the metabolic newborn screening program now provide assistance as needed to the hearing follow-up program.

The program was awarded another 3 year HRSA grant for Newborn Hearing Screening, Intervention and Follow-up (EHDI) effective April 1, 2008. The program uses the HRSA funds to contract with the University of Tennessee -- Knoxville Center on Deafness for an audiology consultant (0.75 FTE). The audiologist provides training and consultation to hospitals, audiologists and medical providers and works directly with TEIS to develop policies and conduct training. The program also contracts with Family Voices to provide three part-time family support parent consultants to conduct outreach to groups and individual families. Family Voices has information on newborn hearing on their website and initiated a HEAR-TN list-serve. NHS data, forms and information are on the state web site http://health.state.tn.us/NBS/hearing.htm. Steps were implemented to link, for the first time, 2007 newborn metabolic and hearing screening to birth certificate data. Preliminary data from the linking identified infants (1% of the population) that did not receive a blood spot screen or hearing screen; follow-up with the hospitals on these cases was done.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote newborn hearing screening in all birth facilities.			X	
2. Promote the use of the data collection system by all birthing facilities.			X	
3. Provide technical assistance and education to providers.				X
4. Revise, as needed, the directory of hearing providers.				X
5. Coordinate referrals and follow-up on infants with abnormal results.			X	
6. Coordinate the activities of the Newborn Hearing Screening Task Force.				X
7. Distribute educational materials for parents, providers, facilities, and intervention programs.			X	X
8. Utilize survey and assessment materials to monitor				X

effectiveness of program components.				
9. Conduct site visits to hospitals to monitor screening effectiveness, access to evaluation, and parent/provider satisfaction.				X
10. Integrate and/or coordinate data systems related to newborns and hearing.			X	X

b. Current Activities

The percentage of infants screened before hospital discharge increased from 91% of 92,049 births in 2007 to 95% of 90,960 births (preliminary) in 2008, meeting the 95% National Benchmark. In 2008, of the 86,464 screened, 3.6% infants did not pass (national benchmark less than 4%). 1,447 (1.6%) of all infants screened were reported to have at least one risk factor for hearing loss. In 2007, 66% completed further hearing testing; in 2008, 67% (preliminary).

Biannual meetings with the Newborn Hearing Task Force/ subcommittees continue. 20 representatives attended the 2009 Early Hearing Detection and Intervention Conference, including parents, audiologists, early intervention, hospital hearing screening, TN-AAP, epidemiologists, and audiology students.

The Hospital Newborn Hearing Screening Guidelines have been revised to reflect recommendations of the 2007 Joint Committee on Infant Hearing and will be distributed to all birthing hospitals with a newborn hearing screening training CD/DVD.

The Department was awarded a 3 year CDC Early Hearing Detection and Intervention, Tracking, Surveillance and Integration grant July 2008. Activities will establish an integrated dataset by combining EHDI data, newborn metabolic data, TEIS data, birth records, birth defects registry, immunization registry, and other relevant state data. Nurses will conduct follow-up on infants with pending results, need further testing due to risk factors, and track others to reduce loss to follow-up.

c. Plan for the Coming Year

The program plans to increase the number of infants screened from 95% to 96% by January 2010 and to reduce the number of infants that do not receive follow-up testing from 34% to 25%. Training activities will be developed for medical providers and early intervention service coordinators. New resources will be developed for Tennessee parents of children identified with hearing loss. In addition, NCHAM developed a new brochure for parents of children with hearing loss that has general and state specific hearing resources. Brochures were received by the program in March 2009 and will be distributed to audiology centers to provide to families of newly diagnosed infants and children.

Coordination of CDC grant and HRSA grant activities and staff will continue for the purpose of meeting HP 2010 and JCIC goals related to early hearing screening by one month of age, diagnosis by three months of age and implementation of early intervention services by 6 months of age.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	7	6	6	6

Annual Indicator	10.8	6.4	6.4	6.4	8.0
Numerator	173220	97933	97933	88283	115407
Denominator	1603892	1530196	1530196	1386911	1442593
Data Source					2008 Kids Count Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	6	6

Notes - 2008
Data source is the 2008 Kids Count Data.

Notes - 2007
Data source is National Survey of Children's Health.
93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

Notes - 2006
Data source is National survey of Children's health.
93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

a. Last Year's Accomplishments
Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census Bureau, 2007 Annual Social and Economic Supplement, Current Population Survey data show that nationally 84.7% of all persons and 89% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2005-2007 show that 5% of the 76,000 children under age 19 and at or below 200% of poverty were without health insurance in Tennessee.

The state's managed care program for Medicaid recipients remains the major source of health insurance coverage for children. As of January 15, 2008, 672,291 children ages 0 to 21 years were enrolled in TennCare statewide.

The Department of Health has entered into participating provider agreements with all of the TennCare Managed Care Organizations (MCOs) to provide services to TennCare members. The Bureau also had agreements with selected MCOs to provide gate keeping primary care services in two rural regions. Since July 2001, TennCare has requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings to TennCare enrollees. During FY 2007-08, health department clinics provided 58,428 EPSDT screenings to TennCare enrollees.

All local health departments offer pregnancy testing. If the patient is pregnant, the health department screens for income and determines if the woman qualifies for prenatal presumptive eligibility, a TennCare Medicaid category of coverage for pregnant women. Four criteria must be met for the woman to qualify for presumptive eligibility: Tennessee residence, valid social security number, household income at or below 185% federal poverty level and verification of pregnancy. The information is entered into the TennCare eligibility system directly by health department staff

so that the women are immediately on TennCare and eligible for coverage of needed services for at least 45 days. TennCare coverage will end after the 45 days of presumptive eligibility unless a TennCare application is made with the Department of Human Services and the woman is approved for continued coverage in TennCare.

All children enrolled in the Children's Special Services program are required to apply for enrollment in TennCare. Ninety percent of children in the program receiving medical services are on TennCare. Each child is assigned to a program care coordinator who assists the family in accessing needed medical services, including preventive, routine medical care, and specialty care. The care coordinator also assists the family with the TennCare appeals process, as needed.

All local health department clinics provide advocacy and outreach for TennCare, and through contact with low income persons and families receiving a wide variety of services (home visiting, family planning, immunizations, etc.) make referrals to the Department of Human Services (DHS) for potential enrollment into TennCare.

Tennessee's CoverKIDS Children's Health Insurance Program is available for uninsured children age 18 and younger whose families earn within 250% of the federal poverty level but are not eligible for TennCare. Maternity coverage is also available for pregnant women through CoverKIDS. Children in families with a household income greater than 250% of the federal poverty level may buy into the CoverKIDS plan with premiums. Benefits are similar to those offered to dependents of state employees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and advocacy services in all health department clients for TennCare enrollees.		X		
2. Provide EPSDT screenings for TennCare enrollees.	X			
3. Provide EPSDT screenings for children in State custody.	X			
4. Continue the EPSDT community outreach project.		X		
5. Provide presumptive eligibility for pregnant women in all health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in TennCare.		X		
7. Assist TennCare enrollees with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities

For FY 2007, TennCare data show that there are 816,486 children ages 0-21 years on TennCare. Of these, 58,058 are less than age one, and 152,575 are ages 6-9. All local activities described in the report of last year‘s accomplishments continue. Referrals are made to the Department of Human Services (DHS) for TennCare enrollment of any families with children who may qualify. All local health department clinics provide presumptive eligibility for pregnant women to enroll in TennCare and referral to DHS for enrollment. All health department clinics provide EPSDT screening exams for children.

Currently, county health departments in two rural regions are primary care provider (gatekeeper) sites and have been assigned TennCare clients by the managed care organizations. These

enrollees include persons of all ages. The Department continues its TENNderCare outreach initiative to encourage parents of children and youth to take advantage of free TENNderCare screenings for their children.

Data from March 2009 show that approximately 35,000 children have been enrolled in the CoverKIDS Program since March 2007.

c. Plan for the Coming Year

Departmental activities related to children and insurance coverage described previously will continue: enrollment of pregnant women in TennCare under presumptive eligibility; enrollment of CSS children in TennCare and assistance with access to care by the care coordinators; provision of EPSDT screenings for TennCare children; outreach and advocacy activities for TennCare enrollees; EPSDT community outreach initiative; EPSDT Call Center; provision of primary care services in selected counties; and referral of children/families to DHS for TennCare enrollment.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			9	9	30
Annual Indicator		10.3	24.2	34.0	15.1
Numerator		20474	22265	53971	11192
Denominator		197847	92164	158733	74293
Data Source					TN. State WIC Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	14	14	12	12

Notes - 2008

Data source is the Tennessee WIC database and calendar year data. Difference from previous year is due to accuracy of number of 2-5 year old participants and changes in methodology to pull these data.

Notes - 2007

Data source is the State WIC database and is the calendar year data. Variation is due to calendar year data, decrease in the the total number of children within the age group of 2-5 years receiving WIC. Data categories may include children under the age of 2 years to 5 years.

Notes - 2006

Data source is the State WIC data base and is the calendar year data
Variation is due to calendar year data and methodology of data count.

a. Last Year's Accomplishments

All WIC children are measured for height and weight; BMI is calculated for each child. If the BMI is above the 85th percentile, the family/parent/caregiver is provided individualized nutrition counseling sessions, and tracked until age 5. To address the child's health problems, the nutrition counselor assists the family in setting goals for the child.

Utilizing the state PTBMIS computer system, specific surveillance data was obtained and examined using the Centers for Disease Control (CDC), Pediatric Nutrition Surveillance System [Ped NSS (pre2004 version)] to calculate provisional analysis. Final results were prepared by CDC. Preliminary information was supplied to 14 regional nutrition directors for the development of FY 08-09 nutrition plans. Two different reports were initiated or made available at this regional level. The High/Low listing was supplied on a bi-monthly basis which showed only participants whose certification values were outside the range for age and gender. These listings also provided the BMI for all participants that appear on this report. A second set of reports was developed listing individuals with assessment values judged to potentially impact the development and wellness of the participants. In FY 08-09 each region developed an activity addressing overweight in their state plan.

In order to detect changes in the percentage of overweight and/or risk of overweight almost all of the clinic locations providing WIC services were equipped with electronic digital scales. Calibration procedures were in place to promote correct weight determinations in the clinics. Techniques used to assure accurate weight, and hematology were periodically reviewed and/or technical assistance provided. In addition to tracking BMI, the incidence of anemia was followed if markedly unusual change in the incidence of anemia was reported. The anemia data was divided on the basis of age: children <24 months of age and those 24-60 months. This division was instituted to identify progress toward the goal of Healthy People 2010.

See State Performance Measure 9 for information on the Gold Sneaker Program implemented in licensed child care facilities to enhance physical activity and nutrition policies with the goals of building lifelong skills for living a healthy life. The National Governors' Association funded the project and recently did a case study on the program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide data and provisional analysis to regional and local nutrition directors for program development.				X
2. Assist with training when policy/procedural changes are instituted.				X
3. Provide nutrition counseling to WIC participants with BMI at or above the 85 th percentile.	X			
4. Provide up to date information of overweight and anemia to local health department programs.				X
5. Monitor compliance with policy and completeness of data at regional and local WIC program levels.				X
6. Provide technical assistance on as needed basis to regional nutrition, nursing and clerical directors.				X
7. Continue to utilize the state PTBMIS computer system for surveillance.			X	X
8. Continue to examine (CDC) Pediatric Nutrition Surveillance System to calculate provisional analysis for program planning and development purposes.			X	X
9.				
10.				

b. Current Activities
All regions are kept up to date on the incidence of overweight and anemia in the pediatric WIC participants. The reports provide indicators of correctness, compliance with policy, and completeness of data on both initial and recertification of WIC participants.

Discovery of marked changes in percentages of participants classified as overweight and/or anemic is followed up with regional staff. If discussions with regional nutrition, nursing and clerical directors lead to requests for technical assistance, it is provided to the specific discipline/s involved.

The Office of Child Nutrition and Wellness is collecting data on "who is the trusted messenger" of nutrition information for young mothers -- i.e., where do they get their feeding information, and who do they listen to or go to with a question. The Nutrition and Wellness Advisory Council is performing statewide surveys to gather data and form recommendations for targeting nutrition messages to young mothers.

c. Plan for the Coming Year
The reports will continue to be provided and upgraded. It is anticipated that the state will begin using the new PedNSS reporting format in the coming year. Appropriate techniques used in assessment and data input will be followed. The incidence of anemia as well as BMI at the 85th percentile will be tracked and reported. Methods to specifically illustrate high percentages variables will be sought. Special attention to detect and reasons for identified condition will be followed up. Assistance with training, when policy/procedural changes are instituted, will be provided. When requested by regional staff, any technical assistance will also highlight the excellence of the work as well as areas where changes are needed.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			9.7	9	7.5
Annual Indicator		16.2	15.8	19.4	14.9
Numerator		13158	13288	16774	12728
Denominator		81454	84277	86558	85443
Data Source					2008 Tennesse provisional Birth master files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	13	13	13

Notes - 2008
Data source: 2008 State of Tennessee provisional Birth master files (Tennessee residents only) Tennessee Health Statistics system.

Notes - 2007
Data source is the State vital records

Notes - 2006
Data source is the State vital records

a. Last Year's Accomplishments
Assisting pregnant women who smoke with cessation has long been a priority of staff within the Department of Health. Staff counsel pregnant women and provide education, information, and referral to community smoking cessation classes and to quitline resources. For four years the March of Dimes funded a smoking cessation project in the Department's WIC clinics for pregnant women, called S.M.A.R.T. Moms (Smart Mothers Are Resisting Tobacco). The grant funding also included training for health department providers and education and outreach to private health care providers. S.M.A.R.T. Moms has been part of prenatal counseling in the WIC program since 2002 and because of its proven success, the S.M.A.R.T. Moms program was made an integral ongoing component of WIC services. Counseling is provided to all WIC pregnant women who smoke using the education guide developed by ACOG. Over 21,000 pregnant women are served by the WIC clinics; this represents 25% of the total resident births. According to birth certificate data, 19.4% of births in 2007 were to women who smoked. However, there is great variation across the state with higher smoking rates in the eastern counties.

In September 2007, the Department of Health began a new tobacco initiative (Smoke-Free Tennessee) which targeted reproductive age women and teens: It included: 1) evaluating all health department clients, 13 years or older, on smoking status and implementing the evidence-based 5As or 5Rs approach; and 2) if client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment (for non-pregnant clients). This effort has significantly increased the number of QuitLine users and persons agreeing to take smoking cessation medications. In the same year, the cigarette tax was increased from 20 cents to 62 cents, and the Non-Smokers Protection Act prohibiting smoking in most restaurants and work places went into effect.

Opportunities in local health department clinics for educating and counseling pregnant women regarding smoking include pregnancy testing (82,051 in CY08), enrollment in TennCare/Medicaid through presumptive eligibility (17,364 in CY08), WIC, and the HUGS home visiting program. The prenatal care guidelines and protocols for nurses and the home visiting protocols provide guidance to staff on assisting pregnant women. The Department operates a centralized EPSDT/TennCare call center to contact TennCare pregnant women and mothers of infants regarding access to care, appointments, referrals, and education on healthy behaviors.

The Governor's Office of Children's Care Coordination awarded a $1.44 million 4-year grant to East Tennessee State University to implement an evidence-based smoking cessation program for 4,200 women in Northeast Tennessee, where rates of smoking during pregnancy are near 40%. The project will also provide case management to 2,100 women for support of smoking cessation efforts, to increase prenatal care use, and to assist with reducing life stressors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide WIC/Nutrition services, including S.M.A.R.T. Moms smoking cessation, in all local health department clinics (all counties).	X	X		

2. Provide pregnancy testing, counseling, referrals, and presumptive eligibility for TennCare enrollment in all health department clinics.	X	X		
3. Provide home visiting services for pregnant women.		X		
4. Offer comprehensive prenatal care services, including counseling and education, in 10 counties.	X			
5. Support the activities of the TennCare/EPSDT Call Center staff related to calls to pregnant women and new mothers.		X		
6. Support the State's activities of Smoke-Free Tennessee.	X	X		X
7. Work with the Governor's Office on Children's Care Coordination on initiative to improve birth outcomes.	X			X
8.				
9.				
10.				

b. Current Activities

The State is continuing to provide all the services described above. All health department clinics offer pregnancy testing. Currently, ten counties offer full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients, who are then delivered by private physicians. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery. They are enrolled in WIC or CSFP, the state's two supplemental food and nutrition programs. There are 140 WIC clinics statewide. Pregnant women are assessed for eligibility in one of the home visiting programs; all 95 counties have home visiting services for pregnant women. All these visits provide opportunity for counseling on the effects of smoking on the pregnant woman and her baby and offering assistance in stopping.

c. Plan for the Coming Year

The Department will continue to provide the services described above (pregnancy testing, counseling, referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and its tobacco cessation program).

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6.5	6	6	6	5.2
Annual Indicator	10.3	7.5	8.7	6.9	5.6
Numerator	42	31	36	29	24
Denominator	407744	411299	414947	422058	426040
Data Source					2008 Tennesse provisional Death master files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	5	5	5

Notes - 2008
Data source: 2008 State of Tennessee provisional Death master files (Tennessee residents only) Tennessee Health Statistics system

Notes - 2007
Data source is the State vital records registry.

Notes - 2006
Data source is the State vital records registry.

a. Last Year's Accomplishments
The Director of Adolescent Health continued to participate as an active member of the Tennessee Suicide Prevention Network (TSPN), and attended the bi-monthly intra-departmental meetings to address suicide prevention issues. The adolescent health guide, "Your Health is in Your Hands" was distributed throughout the state upon request. The guide contains suicide warning signs and provides national and state contact numbers. About 200,000 guides in English and Spanish were distributed statewide, exhausting the supply.

Complimentary booklets, wallet sized contact cards, and magnets from the National Suicide Prevention Lifeline were also distributed. Information included suicide warning signs, the 1-800-273-TALK number, and survivor information for those having attempted suicide or having lost someone to suicide.

Suicide prevention training was provided in several health department regions this past year. The SAMSHA youth suicide prevention grant in partnership with the Tennessee Department of Mental Health and Developmental Disabilities was received and implemented. The awarded grant proposal called for all the Department's public health nurses working in local health departments to receive youth suicide prevention gatekeeper training. Over 900 nurses received training over a two-year period. Teaching tools and informational materials were developed for training a variety of professionals who work with youth, including public health nurses, police officers, nurses, physicians, teachers, coaches and clergy. The Tennessee Department of Mental Health and Disability Disorders (TDMHDD) also provided an educational table exhibit for the 2008 Celebrating Healthy Choices for Youth Conference.

The teen suicide rate has decreased from 10.3 in 2004 to 6.9 in 2007 per 100,000. Teachers are mandated by Public Chapter 45 to receive 2 hours of in-service training on teen suicide prevention. From July 2008 to March 2009 a total of 1,185 teachers attended a classroom in-service, and 13,199 participated in on-line prevention training.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute youth health guides statewide to providers and youth (Suicide information is included)			X	
2. Partner with the Tennessee Suicide Prevention Network (TSPN).				X
3. Participate on the TSPN subcommittee on youth suicide				X

prevention plan.				
4. Assist with carrying out the State Youth Suicide Prevention Plan.			X	X
5. Update and distribute fact sheets on adolescent suicide prevention statewide.				X
6. Provide suicide prevention training for public health nurses.				X
7.				
8.				
9.				
10.				

b. Current Activities
The Director of Adolescent Health continues her collaboration with the Tennessee Suicide Prevention Network and has updated data on numerous educational fact sheets available on the Department website. Fact sheets address the Healthy People 2010 objectives for adolescent health.

Materials from the National Suicide Prevention Lifeline are distributed upon request. A second complimentary youth guide was identified from the National Office on Women's Health; the "Teen Survival Guide" contains information regarding stress, depression, self-esteem, body image, self-injury, and suicide. Readers who think about injuring themselves or about suicide are directed to the National Hopeline Network at 1-800-SUICIDE number or to their telephone directory for a local suicide crisis center.

TDMHDD received a second youth suicide prevention grant focusing on youth in the Juvenile Justice system. Adults that work in the Juvenile Justice system will receive advanced suicide gatekeeper training using the ASIST model. Youth will receive peer youth suicide awareness training and in-depth resiliency programming.

The training of the public health nurses continues.

c. Plan for the Coming Year
The Director of Adolescent Health will continue to partner with the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Suicide Prevention Network to implement the SAMSHA grant.

The Department is currently re-ordering additional copies of ‘Your Health is in Your Hands" for distribution. Complimentary materials from both the National Suicide Prevention Lifeline and www.girlshealth.gov will continue to be made available throughout the state.

TDMHDD will continue to distribute regional suicide prevention resource directories to all local health departments in Tennessee.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	80	80	80	80	80
Annual Indicator	72.3	68.0	69.3	68.5	68.2

Numerator	815	922	1045	1036	940
Denominator	1128	1356	1508	1513	1379
Data Source					2008 Tennesse provisional Birth master files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
Data source: 2008 State of Tennessee provisional Birth master files (Tennessee residents only) Tennessee Health Statistics system

Notes - 2007
Data source is the State vital records registry.

Notes - 2006
Data source is the State vital records.

a. Last Year's Accomplishments
Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and is only used for statistical analysis. Data from 2004-2007 show a range of 68.0% to 72.3% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2008 for this indicator show little change from 2007. Provisional data for 2008 for total very low weight births, as compared to 2007, show a decrease of 135 infants; the rate changed from 1.8 to 1.6 with total births increasing in number. Data for live births 500-1499 grams in hospitals show that 69.6% were born in tertiary level hospitals.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation to all health care providers within the respective geographic area. This system has been in place in the state since the 1970s and is well established and recognized. Medical staff in all five centers are available for 24 hour consultation for both high risk obstetrical and neonatal care. Education and training for providers within the geographic areas is provided by all the centers. An advisory committee, established by legislation and coordinated by Women's Health staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area.

The managed care environment for Tennessee Medicaid plays a role in the low rates of VLBW infants being born in tertiary level hospitals. Also contributing is the difficulty in capturing data on the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory.

All services within the regional perinatal centers continued during the past year. Women's Health personnel worked with the Perinatal Advisory Committee to start the process of reviewing and

revising the regionalization guidelines.

During state FY 2008, the five obstetrical perinatal centers had 14,144 deliveries for Tennessee residents (out of 86,771 resident births for CY 2007), documented 1,597 telephone consultations and 17,623 onsite patient consultations, and taught 2,132 hours of education. Data from the five neonatal perinatal centers for the same time period show 2,642 in-born admissions to Tennessee residents, of which 475 were VLBW (2007 VLBW births were 1,514); 1,305 transports; 2,327 on-site consultations; and 3,075 hours of education taught.

In November 2007 the Perinatal Advisory Committee and the Department of Health sponsored a Community Forum to explore a statewide quality collaborative to improve birth outcomes in the state. Attendees, including perinatologists, neonatologists, hospital administrators, third party payors, state officials, and community constituents, heard information from collaborative initiatives in California, North Carolina, Ohio, and Vermont; proposed implementation strategies for Tennessee; and began work on an action plan. The Tennessee Initiative for Perinatal Quality Care (TIPQC) was begun.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the perinatal regionalization system.	X			X
2. Coordinate the activities of the Perinatal Advisory Committee.				X
3. Update and revise perinatal program manuals as needed.				X
4. Partner with TIPQC.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The structure of the five regional perinatal centers continues to be in place. The state (TennCare) contracts with each of the centers to support the infrastructure of the centers (consultation, professional education, maternal-fetal and neonatal transport, post-neonatal follow-up, data collection, and site visits to hospitals upon request). Staff at all centers are available to health care providers in the appropriate geographic area to provide consultation, assistance and referral for any high risk pregnant woman or infant. The revision to the regionalization guidelines ("Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities") will be completed this year.

TIPQC was officially launched in October 2008 with the goal of engaging providers across the perinatal spectrum in statewide, evidence-based and data-driven quality improvement projects. Funded by the Governor's Office of Children's Care Coordination, over 170 physicians, nurses, advocates, payers, hospital administrators, government leaders, and families met in March 2009 to collaborate on ways to reduce infant mortality and morbidity. The first statewide project will be on improving the temperatures of very low birth weight babies upon admission to the NICU. Nationally, the majority of VLBW babies are cold upon admission to the NICU. Future projects will target increasing breastfeeding rates and reducing elective deliveries before 39 weeks.

c. Plan for the Coming Year

The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise manuals as needed. Work on the revision to the nursing educational guidelines will start during the coming year. A new work group will be formed to review and revise the "Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport Nurses" manual.

The Department will continue to partner with TIPQC on the planned quality improvement projects.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	80.4	60.4	62.5	63.7	64.0
Numerator	64000	49163	52684	55134	54644
Denominator	79590	81454	84277	86558	85443
Data Source					2008 Tennesse provisional Birth master files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
Data source: 2008 State of Tennessee provisional master files (Tennessee residents only) Tennessee Health Statistics system

Notes - 2007
Data source is the State vital records registry.The data is estimated.

Notes - 2006
Data source is the State vital records registry.

a. Last Year's Accomplishments
2007 birth certificate data show that 64.3% of pregnant women started prenatal care in the first trimester; however, these data continue to reflect problems in using the revised birth certificate format and an incompleteness of the data. Prior to implementation of the new format, over 80% of women were starting prenatal care in the first trimester. There is no other known reason for the drop in the percentage except for the new format. Data from the TennCare/Medicaid HEDIS report show that for 2007 77.57% of their enrollees entered prenatal care in the first trimester. Forty-nine percent of the 2007 births in Tennessee were TennCare/Medicaid recipients.

The Department of Health has historically considered the reduction of infant mortality and

improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal care, which includes pregnancy testing (82,051 in CY 2008), presumptive eligibility determination for TennCare (17,364 enrolled in CY 2008), WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Women are also referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD). Tennessee's WIC program is experiencing increasing numbers of participants-numbers are at a record high.

Under the TennCare managed care system in place under TennCare, most prenatal care is provided by private sector providers. Local health department clinics provided comprehensive prenatal care in 10 counties. Delivery services are by a private physician in the community. Many of these counties are serving primarily Hispanic clients; most do not have insurance or do not qualify for TennCare. During CY 2008, 2,289 pregnant women were provided comprehensive care, and of these, 23% were self pay (not on TennCare) and 73% were Hispanic.

Implementation of the PRAMS project began in May 2007. First year PRAMS data based on interviews of 2007 birth mothers have been analyzed, and a report will be distributed internally in the Department of Health and to our working partners by summer 2009.

Using funding from the State, the Governor's Office of Children's Care Coordination has worked to develop an initiative to improve birth outcomes in Tennessee. After first assessing need related to obstetrical care and infant mortality and partnering with numerous agencies and providers, programs and projects, using evidence-based models, have been implemented in Memphis, Chattanooga, Nashville, and Northeast Tennessee. Newly funded activities in 2007-8 include intervention for pregnant smokers, Centering Pregnancy clinical services, youth messaging project, obstetrical faculty to increase capacity for services, health education for pregnant women, education and outreach for pregnant Hispanic women, Community Voice in Memphis (grassroots, community education program), and pilot projects for fetal-infant mortality review teams.

The Campaign for Healthier Babies operating in Memphis since 1993 is a media/educational effort to improve rates of first trimester prenatal care entry and birth outcomes. The Campaign centers around a toll-free number promoted through television, newspaper, and print materials. Callers receive a free Happy Birthday Baby Book of information and merchandise coupons to be validated at prenatal visits. In CY 2008, 7,686 phone calls were received at the Shelby County Health Department and 6,942 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (11,275 brochures), were mailed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 10 counties.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Work with the Campaign for Healthier Babies in west Tennessee.			X	X
6. Continue operating the toll free Baby Line.	X	X		
7. Coordinate with the Governor’s Office of Children’s Care Coordination on the efforts to expand the availability of	X			X

obstetrical services in targeted areas and on implementation of FIMR.				
8.				
9.				
10.				

b. Current Activities
All previously described activities continue. Emphasis is placed on providing pregnancy testing, assisting with prenatal care or arranging referrals to community private health care providers and offering home visiting services. 10 health departments offer full prenatal care. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician and are enrolled in WIC or CSFP. February 2009 WIC data show that 21,345 pregnant women were participating in WIC in 140 clinics.

The Governor's Office of Children's Care Coordination is a vital partner in the effort to improve birth outcomes by funding programs and projects in areas of high numbers of infant death. New projects for 2008-9 include health screening for adolescents, infant mortality television ads in Memphis, a statewide collaborative called the Tennessee Initiative for Perinatal Quality Care (TIPQC) to improve health outcomes for mothers and infants through quality improvement methodologies; phase two of a youth messaging initiative, and evaluation of Centering Pregnancy programs. FIMR teams are being organized, and work has begun in one of the metro counties.

The central office continues to operate the toll free Baby Line. Staff in the Department's EPSDT/TennCare call center contact all TennCare pregnant women and mothers of infants (birth to one year of age).

The report on PRAMS questionnaires with 2008 birth mothers will be available early in 2010.

c. Plan for the Coming Year
All previously discussed activities will continue into the coming year. Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems

D. State Performance Measures

State Performance Measure 1: *Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	30		28	28	26
Annual Indicator	27.6	25.0	25.0	25.0	15.6
Numerator	515	385	385	385	319
Denominator	1865	1540	1540	1540	2041
Data Source					2007 Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	26	26	26	26

Notes - 2008
2007 Youth Risk Behavior Survey

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education. 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used for 2007 data.

Notes - 2006
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2006

a. Last Year's Accomplishments
The Department of Health was allocated state funding to continue the efforts for a comprehensive Tobacco Use Prevention and Cessation initiative (TUPCP). The Department's implementation plan for this appropriation includes expanded cessation services offering counseling, nicotine replacement aids and medications to be offered in local health departments across the state. Clinical medical and pharmacy protocols, provider training, dispensing of medications and data collection are included in the Department's plan of action. Local health departments are monitored according to data collection and clinical protocols with follow-up staff training and assistance.

The TUPCP continued the QuitLine web page which is accessible from the Tennessee Department of Health's website, http://health.state.tn.us/tobaccoquitline.htm, and allows our regional staff, community projects, internal and external partners to freely print information on the services provided by the QuitLine, access promotional print materials and best practice strategies for offering services and treating tobacco use and dependency.

As a part of the tobacco use cessation counseling in the clinics, referrals are made to the QuitLine resulting in an increase in the current Quitline contract. Oversight and administration of the QuitLine contract is imperative to the referral mechanism, and data were collected reflecting all Quitline referrals, counseling, quit attempts, and volume of calls.

From August 2006 to December 2008, the QuitLine has received a total of 24,707 calls. Seven thousand nine hundred and thirty callers (32%) completed the intake process and were assigned to a Quit Coach. Of the callers assigned to a Quit Coach, 5,627 callers (72%) have enrolled into the "iCanQuit" tobacco cessation program and 179 self-help information packets have been distributed.

TUPCP secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows, medical center journals, health system web reports, press releases, national, state and local newspapers and health professional publications.

More than $1 million was provided to all 95 county governments for community-based programs designed to reduce nonsmokers' exposure to second hand smoke. All counties participated in either an anti-tobacco media literacy curriculum and/or a community anti-tobacco and smoke-free media campaign. A total of 232,329 youth in grades K-12 participated in the curriculum from the CDC. Pre and post surveys indicated positive changes in knowledge about tobacco use and attitudes. Community media campaigns in 58 of the 95 counties focused on anti-tobacco and smoke-free messages. Examples include billboards, banners at organized events, community cable TV, and news articles.

The Student Tobacco Outreach and Prevention Program (STOP) has been designed to implement best practices and proven strategies in Tennessee's effort to target adolescents and tobacco use. The program utilizes school-wide and community-wide interventions to promote

awareness of tobacco dangers in nine rural counties with high smoking rates and low socioeconomic indicators. The overall mission of the program is to reduce illness, disability, and death related to the use of tobacco and exposure to secondhand smoke. The pilot program began in August/September 2008 and ran through the academic school year to June 2009. The program preliminary evaluation showed the following: (1) approximately 25% of the high school populations of the nine counties participated in one or more STOP project activities; (2) strengthening of wellness policies and receipt of STOP materials (e.g., videos, instructional materials, and other resources) that will continue to be used by the schools in future years; and (3) integration of anti-tobacco information and activities into school curricula.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen local health department clients for tobacco use and offer assistance.	X			
2. Continue the Tennessee QuitLine.	X	X		
3. Provide education and awareness through State web site.			X	
4. Collaborate with partner agencies.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Cessation services, including counseling, nicotine replacement aids and medications, continue to be offered in all local health department clinics. The Tennessee QuitLine is available to citizens statewide.

Collaboration and partnerships on policy efforts continue to grow with the state advocacy coalition-Campaign for a Healthy and Responsible Tennessee (CHART) and other partners across the state. There are a total of 1,880 members involved in state and local coalitions.

In February 2008, TUPCP with advocacy partners CHART, American Heart Association, American Lung Association, and the American Cancer Society participated in the first CDC sponsored state training on the development of a Sustainability Plan for state funding of tobacco control. TUPCP contracted with the Tobacco Technical Assistance Consortium to facilitate a strategic planning process to develop a new state plan for 2009-2013. With the assistance of more than 40 partners, representing tobacco regulation, enforcement, advocacy, health communication, community based programs, insurers, and health centers, a draft state plan for tobacco use prevention, control and cessation was created.

Two high schools in an East Tennessee county whose students developed anti-tobacco commercials for the community media campaign won awards for their productions. On March 25, 2009, one 30-second commercial was a regional winner, and another 30-second commercial won a national merit award.

c. Plan for the Coming Year

The Tobacco Program will continue to collaborate with CHART (Campaign for a Healthy and Responsible Tennessee), a grassroots coalition, to educate the public and motivate Tennesseans to advocate for moving policy change at the state level. The Tobacco Program through its youth empowerment focus will partner with CHART and other agencies to hold Youth Tobacco Summits in West, Middle and East Tennessee. The Youth Tobacco Summits will impart skills to empower youth to present tobacco prevention issues to their local legislatures and to civic groups and present their communities' views on tobacco policy issues.

The Department of Health's program will continue to raise awareness of the dangers of tobacco use; mobilize the general public and priority populations; build capacity of state and local coalitions to effect tobacco related social norms, promote environmental change and support grass roots advocacy for non-tobacco policy. The program plans to strengthen its relationships with internal and external partners by convening quarterly meetings of the multiple strategic planning workgroups and maintaining monthly technical assistance and training teleconferences with regional staff and community program staff.

State Performance Measure 2: *Reduce the percentage of high school students using alcohol.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	38		36	36	34
Annual Indicator	41.1	41.8	41.8	41.8	35.9
Numerator	772	643	643	644	686
Denominator	1878	1540	1540	1540	1909
Data Source					2007 Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	34	34	34	34	34

Notes - 2008
2007 Youth Risk Behavior Survey

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education
2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2007

Notes - 2006
Data source is the Tennessee YRBS conducted by Tennessee Department of Education
2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2006

a. Last Year's Accomplishments
The Tennessee Department of Mental Health and Developmental Disabilities, Division of Alcohol and Drug Abuse Services provides primary prevention programs for youth who do not require treatment for substance abuse. Prevention services were primarily focused on the target population of youth under the age of 18. In addition to existing program categories (Intensive Focus, Faith Based, Deaf and Hard of Hearing, Tennessee Teen Institutes, Community Prevention Initiative, and the Statewide Clearinghouse), the Division also contracted with Big Brothers Big Sisters of Middle Tennessee and the Boys and Girls Club of the Middle Tennessee Valley to provide services during FY 2008.
The Big Brother Big Sisters of Middle Tennessee's (BBBSMT) mission is to help children reach

their potential through professionally supported, one-to-one relationships with measurable impact. Matches, the term used to identify adult volunteer Big Brothers or Sisters and their Little Brothers or Sisters, meet weekly and spend time together on a variety of activities. The program has been shown to have positive effects including, increased self-confidence, improved school performance, and better interpersonal relationships with their families. Little Brothers and Sisters are also less likely to begin using illegal drugs, consume alcohol, skip school and classes, or engage in acts of violence. Amachi is a special initiative within Big Brothers Big Sisters that serves children of incarcerated parents. Targeted children are provided with one-to-one mentor relationships. The mentor and mentee are encouraged to meet weekly and spend time together on a variety of activities.

The Comprehensive Alcohol, Tobacco and other Drug Program uses the SMART (Skills Mastery and Resistance Training) Moves Curriculum, which is a health and life skills program that teaches youth to resist the pressures of drugs and alcohol and premature sexual activity. SMART Moves also teaches youth pro-social and resiliency skills, while increasing their self-awareness, decision-making, and interpersonal skills. In addition, SMART Moves is a nationally-acclaimed comprehensive prevention program proven to have a positive impact in youth's choices to participate in tobacco, drug, or alcohol use. This year-round program encourages collaborations among Boys and Girls Club staff, youth, parents and representatives from other community organizations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide prevention services through a variety of projects funded through Mental Health/Developmental Disabilities.	X	X		
2. Provide mentoring programs for youth.	X	X		
3. Train and educate classroom teachers and school staff about mental health and substance abuse topics.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Existing program categories, (Intensive Focus, Faith Based, Deaf and Hard of Hearing, Tennessee Teen Institutes, Community Prevention Initiative, and the Statewide Clearinghouse) continue to provide prevention services in FY 2009. Additionally, BBBSMT, (see above) and the Boys and Girls Club (see above) provide services. It is estimated that 8,800 youth will be served during FY 2009.

The School-Based Mental Health/ Substance Abuse Liaison (SBMHL) service provides professionals with a background in social work and psychology to consult with, train, and educate classroom teachers and school staff about a variety of mental health/substance abuse prevention topics; to provide liaison services between the school and specific children's families; and to provide information and support for the schools in navigating the mental health/substance abuse system. The goal is to promote school success. Services are provided in all grand divisions of the state and approximately 1,440 children are expected to be served in FY 2009.

c. Plan for the Coming Year

For FY 2010, the Division has issued an Announcement of funding for statewide prevention services. Prevention funding will be targeted to provide evidenced-based prevention services to select populations, such as youth in foster care, youth in the juvenile justice system, and children of substance abusing parents. Funds will be awarded in the following categories:
Tennessee Prevention Network--Funds will be targeted to provide evidenced-based prevention services to select, high-risk populations, such as youth in foster care, youth in the juvenile justice system and children of substance abusing parents. In addition, new programs will target youth engaged in high use behaviors such as binge drinking, prescription drug abuse, and inhalant abuse.
Community Anti-Drug Coalitions--Funds will support coalitions whose work focuses on changing the community environment by examining community policies and practices. Coalitions work with various sectors including law enforcement, health and education agencies to make changes that will decrease the social and health consequences of substance abuse in a community.
Prevention Coordinator--This community-based position will guide the work of community-based organizations, workgroups, coalitions, and others and assist in advocacy, policy, collaboration, and awareness strategies.
Tennessee Teen Institute Program--The Teen Institute is a one-week long "camp" experience where teen participants are taught the skills, education, and information necessary to develop and implement alcohol and drug abuse prevention programs in their own communities.
Higher Education Initiative--The higher education notice of funding will use environmental management strategies and target multiple institutions of higher education to reduce substance abuse and related consequences.

State Performance Measure 3: *Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7.2	7	7	7	7
Annual Indicator	10.5	11.4	10.7	8.3	7.0
Numerator	15143	17500	17500	13528	10039
Denominator	1437424	1530196	1635539	1635539	1442593
Data Source					Tennessee Dept. of Children's Services,
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	7	7	7

Notes - 2008
Data source is the reports from the Tennessee Dept. of Children's Services, Child Protective Services section.
The numerator number is from the Tennessee Dept. of Children's Services, Child Protective Services section.
The total denominator data of 1442593 is from the 2008 KIDS Count data book

Notes - 2007
Reports from the Tennessee Department of Children's Services Child Protective Services Section.

Notes - 2006
Reports from the Tennessee Department of Children's Services Child Protective Services Section.

a. Last Year's Accomplishments
Programs and health system activities that support this performance measure are: the mandatory reporting system; investigation by the Department of Children's Services and prosecution; community based programs for prevention education; the Child Fatality Review System; and the county home visiting programs in local health departments and contract agencies.
2006 data regarding child abuse and neglect rates continues to be the most current information reported by the Tennessee Department of Children's Services (DCS). In 2006, 11.7 children per 1,000 were abused and/or neglected. While responsibility for preventing and intervening in child abuse cases resides in DCS, MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program (CHAD) offers home visiting, parenting training, infant stimulation and basic health care to families at risk of, or previously investigated regarding child abuse and/or neglect. The Healthy Start Program follows the Hawaii Healthy Start and Prevent Child Abuse America's Healthy Families America model of home visitation. Healthy Start provides assessment and referral services for families as well as intensive home visiting services for families with an elevated risk of child abuse and/or neglect. The program targets adolescent and first time parents. The Help Us Grow Successfully Program (HUGS) provides home visits to pregnant women and families of children up through age 5. All of the home visiting programs offer the opportunity to educate and counsel families and make referrals for additional services, as well as provide parent support, child development information, health care information and general parent information. All home visitors are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse. Children presenting to the local health departments for a variety of services including immunizations, WIC and EPSDT are assessed for needed services related to prevention of abuse and neglect.
During FY 2007-2008, the Department provided CHAD services in 22 counties with families being referred to this program by Child Protective Services. CHAD served 1,326 children from 916 families in FY 2008. The Healthy Start Program provided services in 30 counties, targeting first time parents who are in the prenatal period or who are at or near the time of birth. Healthy Start served 1,563 children in 1,309 families in FY 2008. All 1,563 children in Healthy Start were considered at risk for abuse/neglect prior to initiation of services, using the Kempe Family Stress Check List. Program data show that 99.4% of the children were free from abuse and / or neglect and remained in their parents' homes. HUGS provided services to 89 counties. HUGS revised its guidelines and home visiting orientation manuals as well as provided the Ages and Stages developmental screening tools training to home visiting staff.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide home visiting services to pregnant women and families of infant and young children.		X		
2. Provide technical assistance, training and resources to child care providers through the network of Child Care Resource and Referral Centers.				X
3. Make referral for families accessing any type of health department programs and needing additional services.		X		
4. Implement the long term plan for Early Childhood Comprehensive System Planning grant.		X		
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHAD served 22 East and Northeast Tennessee counties in fiscal year 2008. Healthy Start serves 30 counties through its contract program. Healthy Start of Anderson County is not a contract program, but is an Independent Healthy Start site providing service through a local initiative. New Healthy Start employees in the state funded sites received the intensive initial training provided by Tennessee's National Healthy Families America trainer.

HUGS now provides services to all 95 Tennessee counties. HUGs is in the process of automating and standardizing its services to facilitate data collection and reporting. New baseline assessment and encounter screens were designed and are being implemented. Referrals will be tracked electronically and the system has an internal reporting function that can be accessed for summary information about the case load. For many years it has been obvious that the HUGS program was 'charting' a lot of data regarding their home visits, but that little of that data was being automated. Since the beginning of the state's Patient Tracking Billing Management Information System, HUGS visits have been recorded on the patient encounter, but without any information about the visit (other than whom the patients were and how many visits were made to each patient).The program's goals are to improve pregnancy outcomes, improve maternal and child health and wellness, improve child development and maintain or improve family strengths for all family strengths.

c. Plan for the Coming Year

All home visiting programs (CHAD, Healthy Start and HUGS) will continue to provide services. CHAD will serve 22 counties. The CHAD and Healthy Start Program Director will continue to work with the TN Prevention Advisory Committee to improve the child abuse and neglect prevention system in Tennessee. The Program Director will plan a Statewide Conference for Healthy Start Program Coordinators and Family Support Workers.

HUGS will continue to look at ways to provide staff training including a SIDS grief counseling training and a training collaboration with Vanderbilt University Mind series (Mid-Tennessee interdisciplinary Instruction in Neurodevelopmental and Related Disabilities - NDRD Training Project). The objective of the video conferences is to increase access to services for children and families and NDRD. The video conferences address current information on the specific conditions and diseases, including diagnosis and treatment and the role of the Tennessee Department of Health in translating needs into practice to influence health outcomes of Tennesseans. Early Childhood Comprehensive Systems (ECCS) will continue to host meetings to provide public and private agency professionals the chance to collaborate to improve child health. In FY 2008-09, parents will be added to the 11 Child Care Resource and Referral Centers. The role of the parents is to provide technical assistance, training, and resources to child care providers and other parents. They will promote the evidenced-based 5 Protective Factors for Families to prevent child abuse and neglect.

State Performance Measure 4: *Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	80	89	90	92
Annual Indicator	68.1	88.1	88.2	73.3	90.8

Numerator	527845	663876	664879	597536	705348
Denominator	775232	753474	753982	814643	776652
Data Source					TennCare Data Report
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	95	95	95	95

Notes - 2008
Data source is the state of Tennessee TennCare EPSDT Data system.
Data is 1 year late due to TennCare EPSDT reports.

Notes - 2007
Data source is the state of Tennessee TennCare EPSDT Data system.
Data is 1 year late due to TennCare EPSDT reports.

Notes - 2006
Data source is State of Tennessee TennCare

a. Last Year's Accomplishments
This performance measure is determined by the Bureau of TennCare and addresses a statewide measure across private providers as well as Department of Health. A 3% increase for each year may not be feasible since the periodic screening rate projected for 2008 is 90.8%.

All 95 county health departments continue to provide EPSDT screenings to TennCare-eligible children. In FY 2007-08, 58,428 screenings were done by the health departments. The Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2007-08 from DCS show that 93% of children had been screened. The TENNderCare Community Outreach program, the TENNderCare Call Center and the TENNderCare Nursing Call Center raise awareness of the importance of EPSDT screening to parents of TennCare eligible children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide EPSDT screening exams to TennCare enrollees in all local health department clinics.	X			
3. Assist families with referrals to appointment for screening with primary care providers.		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children Services.		X		
5. Implement the EPSDT community outreach project.		X		
6. Continue to operate the TENNderCare Call Center.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The Department of Health operates three components to its outreach program to support the TENNderCare message, "Check In, Check Up, and Check Back." The Community Outreach

Program is centered around community initiatives that promote awareness of the importance of children receiving checkups covered by TennCare. The TENNderCare Call Center, located in Nashville, has Call Center Operators on two shifts who provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are provided education on the importance of TENNderCare services and are advised that the costs of these services are provided by TennCare. With agreement of the parent, the Call Center Operator will contact the member's primary care provider and make an appointment for the child and/or arrange transportation for the member. The Nursing Call Center provides telephone outreach to pregnant women covered by TennCare to discuss the importance of early contact and continuous prenatal care as well as the importance of the health screening for the baby. For state fiscal year 2009, 209,677 calls were completed to families regarding EPSDT services for their children. 8992 EPSDT appointments were scheduled by the Call Center staff for both private providers and health department clinics. It is projected that as many as 57,000 EPSDT screenings will be provided in Department of Health clinics in FY 09.

c. Plan for the Coming Year

The TENNderCare Program will continue the three components of outreach. This should result in increased awareness to parents/guardians of TennCare eligible children about the importance of EPSDT screenings and preventive care.

All local health department clinics statewide will continue to provide EPSDT screening exams for TennCare enrolled children. The Department will also continue to provide EPSDT screening exams for the children in the custody of the Department of Children's Services.

State Performance Measure 5: *Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2
Annual Indicator	6.6	6.9	6.3	6.5	6.2
Numerator	1809	1985	1720	1578	1544
Denominator	27494	28890	27346	24334	25088
Data Source					State of Tennessee STD infertility project data
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2

Notes - 2008

State of Tennessee STD infertility project data system.

Notes - 2007

Data source is the Tennessee Department of Health.
Data source is the State of Tennessee STD infertility project data system

Notes - 2006

Data source is the State of Tennessee STD infertility project data system

a. Last Year's Accomplishments

All family planning clinic sites provide testing for chlamydia and gonorrhea in accordance with protocols jointly established by the STD and Family Planning Programs. In CY 2008, family planning clinics did 44,651 chlamydia tests and 47,173 gonorrhea tests.

Through a cooperative agreement between CDC and the Office of Population Affairs, the Infertility Prevention Project (IPP) has funded and fostered strong collaboration among Title X family planning programs, STD programs, and state public health laboratories. Tennessee, through the family planning clinics and the sexually transmitted disease (STD) clinics, is providing screening and treatment statewide. Screening criteria are determined using CDC national recommendations, state-specific data, and available resources; the criteria are reviewed annually and revised as needed. Significant revisions were made in July 2008. Approximately 120,000 tests are conducted annually. Both state appropriations and federal infertility project funds are available for the program.

Data for 2008 for family planning clinics show a 6.15% chlamydia positivity rate for ages 15-24. This compares to 6.5% for calendar year 2007.

Policies in place to improve treatment for chlamydia include the use of directly observed therapy (DOT) by non medical personnel (public health representatives/disease intervention specialists) using azithromycin for the treatment of chlamydia. This policy provides an option for dealing with the most difficult patients and contacts. Policy also has been in place since 2002 allowing partner delivered therapy within the local health department clinics. Tennessee is one of the few states which has the legal authority to provide medications for partners.

Staff continue to conduct risk assessments and offer chlamydia urine screening to adolescents being provided EPSDT screening exams in the local health department clinics. All women under age 30 reporting to local health department clinics for a urine pregnancy test are offered screening for chlamydia and gonorrhea from their pregnancy test urine sample. This population of women who are also offered family planning if their pregnancy test is negative provides a target group who may never have used clinic services previously. Local health departments began offering this service on September 1, 2006. A comparison of the number of women requesting a pregnancy test who were tested during the first six months of 2006 (prior to implementation of the new policy) and the first six months of 2007 found a 400% increase in the number of tests offered.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen for Chlamydia in family planning and sexually transmitted disease clinics in local health departments.	X			
2. Provide risk assessments and screening for adolescents as part of the EPSDT screening exam.	X			
3. Participate on the Region IV Infertility Project Advisory Committee.				X
4. Encourage use of directly observed therapy by non-medical personnel.	X			
5. Encourage use of partner delivered therapy.	X			
6. Participate in the Region IV Chlamydia Awareness Month.	X		X	
7. Provide information to the public through the Department's web site.			X	
8.				
9.				
10.				

b. Current Activities
Chlamydia screening based on the state's screening criteria (as determined by the 2007 data) is continuing in all family planning and sexually transmitted diseases clinics statewide. Chlamydia screening is also offered to women who request a "walk-in" pregnancy test, and to sexually active adolescents screened during routine EPSDT visits. Representatives from all three programs (Family Planning, STD, and Laboratory) continue to participate on the Region VI infertility prevention project advisory committee. Staffs continue to promote the use of partner delivered therapy in the clinics.

On October 20, 2008, Title X family planning services began at a new site at the University of Tennessee at Martin Health Center. These services for college students include screening for chlamydia and gonorrhea.

The two non-profit family planning program agencies participated in the MTV/Kaiser Foundation STD awareness initiative in April, offering special services and targeted education. Screening occurred during Chlamydia Awareness Month in two colleges in Madison County and one local site in a rural county which houses juveniles from the court system; 162 young people were screened with a positivity rate just under 10%.

Program staff will be analyzing the 2008 chlamydia project data by geographic area, clinic type, age groups, and program. Laboratory costs continue to increase, and state revenues are declining. It is expected that the screening criteria may have to be revised

c. Plan for the Coming Year
Plans include continuing all the activities described in the above sections, using urine-based testing in select youth detention facilities; using urine-based testing in appropriately targeted outreach screening initiatives; using directly observed therapy by non-medical staff for treating chlamydia, and encouraging partner-delivered therapy.

State Performance Measure 6: *Reduce the number of babies born prematurely.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	11	10
Annual Indicator		12.7	12.4	11.7	11.4
Numerator		10241	10454	10162	9760
Denominator		80583	84277	86558	85443
Data Source					2008 Provisional Birth master files.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008
2008 Provisional Birth master files (Tennessee resident only).
Preterm defined as gestation 17-36 weeks.

Notes - 2007
Data source is the Tennessee Department of Health.
Data source is the State of Tennessee provisional birth master files, Tennessee residents only.

Notes - 2006

Data source is Tennessee Birth master files, Tennessee resident only

a. Last Year's Accomplishments
All local health department clinics offer basic prenatal care, which includes pregnancy testing, presumptive eligibility determination for TennCare/Medicaid, WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Pregnant women in all local health departments are referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD). Currently, all 95 counties provide home visiting services. The HUGS home visiting program has implemented a new data collection system which will provide information for evaluating results. Pregnant women who smoke are offered counseling and education through the WIC program and the Tobacco Use Prevention and Control Program. The Tennessee Tobacco QuitLine offers counseling for smokers across the state, and services have been tailored to serve pregnant women who smoke.
Under the TennCare managed care system, most prenatal care is provided by private sector providers. Local health department clinics provide comprehensive prenatal care in 10 counties across the state for primarily uninsured, Hispanic clients. Data on WIC clients for May 2008 show that 21,900 pregnant women were participating in the program.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as 24-hour consultation, transportation, professional education for providers, and technical assistance to facilities and providers. This system has been in place in the state since the 1970s and is well established and recognized. A Perinatal Advisory Committee (PAC) advises the Department on perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, perinatal transportation, and education objectives for perinatal nurses and social workers.

Other important services which can impact the health of women and play a role in lowering the overall prematurity rate are screening for sexually transmitted diseases and family planning. All local health department clinics offer screening for sexually transmitted diseases, including chlamydia, gonorrhea, syphilis, and HIV, and family planning services, including education and counseling, physical exams, laboratory tests, and birth control methods.

Other activities impacting preterm births (Improving Birth Outcomes projects funded by the Governor's Office on Children's Care Coordination, TIPQC, EPSDT Call Center, and TENNderCare outreach and advocacy) are discussed in other sections on the national and state performance measures. It is anticipated that data from the new PRAMS and FIMR programs will assist in developing new initiatives to address the precursors of preterm births in Tennessee.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 10 counties	X			
4. Provide WIC/nutrition services in all local heath department clinics.	X	X		
5. Continue the perinatal regionalization system.	X			X
6. Continue to counsel pregnant women on stopping smoking.	X	X		X
7. Coordinate with the Governor’s Office of Children’s Care Coordination on efforts to expand the availability of obstetrical services in targeted areas, establishment of FIMR teams, and	X			X

other infant mortality reduction activities.				
8. Participate in the TIPQC Initiative.				X
9. Coordinate with PRAMS staff.			X	
10. Implement FIMR in 4 geographic areas.			X	

b. Current Activities
All programs and services described in the previous section continue to be available. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician for prenatal care and delivery. They are also enrolled in WIC or CSFP, the state's supplemental food and nutrition programs, and referred for home visiting as appropriate.

The programs and projects funded under the Governor's Initiative to Improve Birth Outcomes (discussed in NPM 18) are important activities in addressing this measure.

The Tennessee Initiative for Perinatal Quality Care (TIPQC) is currently focusing on two special projects: (1) 20 NICU hospital teams are developing quality improvement projects on NICU admission temperature. (2) 5 Davidson County hospitals are finalizing survey and data collection methods to address reducing elective deliveries before 39 weeks. Regional Advisory Committees are meeting in all five perinatal regions.

c. Plan for the Coming Year
The Department will continue to provide the services described above (perinatal regionalization, pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and smoking cessation counseling).

Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems.

TIPQC projects under development include human milk project, nosocomial infection reduction, and breastfeeding awareness campaign.

State Performance Measure 7: *Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis and Treatment(EPSDT) annual examinations by 5% each year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			50	50	60
Annual Indicator		10.3	9.7	39.4	46.5
Numerator		62000	58313	117570	136925
Denominator		600000	600000	298233	294375
Data Source					TennCare Data Report
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2008

Data source is the state of Tennessee TennCare EPSDT Data system.
Data is 1 year late due to TennCare EPSDT reports.

Notes - 2007
Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data.
Data includes Children age 10-18 years and the data is based on FY 2005-2006

Notes - 2006
Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data.

a. Last Year's Accomplishments
Note that this screening percentage objective is determined by the Bureau of TennCare and covers performance by private providers as well as screening exams at the Department of Health clinics.

During this past year adolescents were a major focus group for targeted outreach by all participating partners and providers, including the Bureau of TennCare, Department of Health TENNderCare Community Outreach Program, and by all the TennCare Managed Care Organizations.

The 2006-2007 CMS-416 Annual EPSDT Participation Report shows that there were 294,315 total adolescents ages 10-18 eligible for EPSDT. Total screens for this age group were 136,925; the screening ratio was 52.99%

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide advocacy and outreach activities in all local heath department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide EPSDT screening exams for children of all ages in all local health department clinics.	X			
3. Assist families with referrals to appointment for screening with primary care providers.		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children Services.	X			
5. Implement the EPSDT community outreach project.		X		
6. Implement the EPSDT community outreach education and screening project.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The Department of Health (DOH) TENNderCare Program has a special focus on EPSDT educational outreach to the adolescent population. All Regional TENNderCare programs include in the regional community outreach plan a section on strategies to target adolescent patients. TENNderCare Program contracts with the six (6) metropolitan health departments include a requirement to conduct outreach activities designed to reach pre-teen, teen and young adult populations.

Currently, the Regional TENNderCare Program Community Outreach Staff in all 13 DOH regions of the state participate in community events that target teens at colleges, vocational schools,

sporting events, health fairs and other activities to educate teens on the importance of preventive health care and getting the EPSDT exam covered by TennCare.

c. Plan for the Coming Year
The DOH Regional TENNderCare Program will continue conducting and participating in outreach efforts targeting adolescents. The TENNderCare Program will have discussions with the three TennCare Managed Care Organizations to explore opportunities to collaborate on strategies for outreach to adolescents.

The Governor's Office of Children's Care Coordination (GOCCC) is sponsoring a special focus group of stakeholders to look at ways to increase the screening rate of EPSDTs for adolescents covered by TennCare. State and private agencies as well as private providers are involved in workgroup meetings which will be conducted in 2009 to address future outreach strategies, including what type of incentives may be effective to encourage adolescents to obtain the recommended EPSDT services as well as to identify barriers for adolescents. Future plans and strategies will build upon the information gained from this special study.

State Performance Measure 9: *Reduce the number of overweight and obese children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	30	30
Annual Indicator		31.9	31.9	39.9	29.6
Numerator		491	491	615	608
Denominator		1540	1540	1540	2054
Data Source					Tennessee YRBSS survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	25	25	25	25

Notes - 2008
Tennessee YRBSS conducted by Tennessee Department of Education.

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education
2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Data source is the State of Tennessee Youth Risk Behavior survey

a. Last Year's Accomplishments
Community Nutrition Staff, in partnership with other programs and coalitions across the state, worked on the following focus areas related to children who are overweight or obese: obesity prevention/awareness, promoting healthful eating, and breastfeeding promotion and counseling.

The Coordinated School Health Program (CHS) Program, mandated by TCA 49-1-1002, and the responsibility of the Department of Education, conducted BMIs on approximately 100,000 Public School children with about 45% of those tested referred to a health professional for nutrition and physical activity counseling. The incidence of overweight and at risk for overweight (above the 85th percentile) was 42%. All Public School Elementary and Middle School children participate in a minimum of 90 minutes per week of physical activity as part of their regular class room activities as mandated by TCA, Title 49, Chapter 6. Each Public School system in Tennessee has a USDA mandated wellness plan that addresses nutrition and physical activity. Many school cafeteria staff are incorporating nutrition education in the cafeteria and other strategic areas of schools. On average one question per day is answered by Registered Dietitians (RDs) on the Community Nutrition staff. These nutrition questions come to the Department from GetFitTN and the Department of Health websites and are quite varied in nature but mostly relate to prevention and treatment of nutrition related chronic diseases. A major focus of the WIC Program is to provide nutrition counseling to participants. In calendar year 2008, nutrition counseling for overweight or at risk for overweight was provided for approximately 82,000 pregnant, breastfeeding, and postpartum women, infants up to 1 year of age, and children to their 5th birthday. See NPM 11 for updates on breastfeeding.

Tennessee was the recipient of funding to develop the Gold Sneaker Initiative designed to enhance policy related to physical activity and nutrition within licensed child care facilities across the state. The aim of the initiative was to encourage child care providers, from both the private sector and the public, to voluntarily adopt physical activity and nutrition policy. Training through the Child Care Resource and Referral Centers was conducted for 435 centers. Fourteen facilities completed the entire process to be designated Gold Sneakers facilities. Currently, the initiative is transitioning to efforts through a Project Diabetes grant with United Way of Greater Chattanooga. Kit Fitness Fun Fitness Break kits are being distributed to child care centers as tools for classroom activities.

Project Diabetes began in 2006 with state appropriations to fund evidence-based projects around diabetes and pre-diabetes prevention and treatment. One of the main objectives is to decrease the prevalence of overweight and obesity. For FY 2009, 45 projects were funded for a total of $7,308,000. In addition, 17 grants were made to school systems in East Tennessee for GoTrybe, a computer-based program for students in grades 9-12, emphasizing physical fitness, nutrition and self-esteem. The program has produced a 128% increase in total physical activity for teachers and 619% for students.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect, manage and analyze ESPDT screening data.	X			
2. Work with TennCare providers on obesity prevention screening.	X		X	
3. Promote healthful eating through Tennessean WIC program.	X			
4. Coordinate with the school health on activities related to overweight and obese children reduction.	X			
5. Provide education and training as requested by school system and professional groups on obesity and Body Mass Index (BMI).	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities described above continue. A CDC obesity planning grant was awarded to the Nutrition and Wellness section of the Department on June 30, 2008, to run through June 30, 2013 (Grant #DP08-805). The Tennessee Healthy Menu Act was introduced to Tennessee's 106th General Assembly in January 2009 (House Bill 2319, Senate Bill 2314, an act to amend Tennessee Code Annotated, Title 68, Chapter 14 and Title 53, Chapter 8). The legislation addresses providing to consumers calorie content information to aid in making more healthful menu choices. This administration bill was sent to a summer study committee and will be brought up again beginning January 2010 in the second half of the 106th General Assembly. In Metro Nashville-Davidson County, Menu Labeling passed through the County Board of Health for large chain restaurants to post calorie content for all menu items served on a regular basis. The City Council is currently addressing this bill.

c. Plan for the Coming Year
The Tennessee Public School vending machine standards (mandated by T.C.A.-49-6-2301 et seq) require the standards committee of the Tennessee State School Board to meet each 5 years after the new Dietary Guidelines are released to update the standards based on implications from new 2010 guidelines. A Registered Dietitian from the Nutrition and Wellness Section represents the Department on this committee. The bill proposed to establish Tennessee's Healthy Menu Act picks up again in January 2010 with the State Legislature. The Nutrition and Wellness Section is the legislative contact section for this nutrition related legislation. Work will continue on the CDC Obesity Planning Grant.

State Performance Measure 10: *Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			100	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		1234	1234	1534	1245
Denominator		1234	1234	1534	1245
Data Source					CSHCN Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data source is the National CSHCN Survey.

Notes - 2007
Data source is the State of Tennessee CSS data system

Notes - 2006
Data source is the State of Tennessee CSS data system

a. Last Year's Accomplishments
CSS was involved in transitional training that was provided by Healthy Ready to Work. This training allowed CSS program staff to develop the resources necessary to create a statewide transitional plan that was used as a model for all individual transition plans. CSS collaborated with the Department of Education, the Department of Mental Health and Mental Retardation, the Tennessee Council on Developmental Disabilities and Family Voices to develop a statewide transition task force that worked on developing transition plans for all children.

CSS worked to identify each and every need a participant and their family will have concerning transition from adolescence to adulthood. CSS worked on the development of a statewide and regional transitional team and continues in the identification of transitional resources within the community. A resource guide to transitions was developed and shared with other agencies, private providers, advocacy groups, families, and other entities interested in transitions to adulthood.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage and analyze data on the transitional plans of adolescent to adult services.				X
2. Continue education of providers, families and citizens.				X
3. Access Community Resources toward transition to adulthood.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is continuing mobilization of a statewide transitional team and plans that can be utilized in the regional and metro areas. The team will comprise parents of children with special health care needs, CSS participants, staff and community agency representatives. Care Coordination standards are being established to standardize and enhance transitional services for the CSS participants. Field staff is being provided technical assistance based on the training received from Healthy Ready to Work. Age appropriate transitional plans will continue to be developed for all participants age 14 and older. A Medical History Summary Form has been developed and will be provided to all CSS participants age 14-21 as a concise medical history that can be provided to medical providers as the participants transition from pediatric medical homes to adult medical homes. The Medical History Summary Form will also be made available to any CSS participant that reaches maximum treatment or terminates from the CSS program.

c. Plan for the Coming Year

CSS will continue to collaborate with Tennessee Department of Education, Tennessee Department of Mental Health and Mental Retardation, Juvenile Justice, Labor and Workforce, Children's Services and representatives from other child serving agencies on the Youth Transition Task Force that addresses all transition services necessary to transition from youth to adults. CSS will continue working with Tennessee Department of Education to include a medical home transition component in the Department of Education transition guidelines. CSS will continue collaborating with the Governor's Office of Children's Care Coordination, Family Voices, TennCare, Vocational Rehabilitation and the Department of Higher Education to develop model transition plans. All CSS participants age 14-21 will have an individualized transition plan that includes components relative to medical home, independent living, higher education, employment and recreation. Healthy Ready To Work will continue to provide technical assistance in the development of transition plans.

CSS will collaborate with the American Academy of Pediatrics to develop emergency

preparedness guidelines for children and youth with special health care needs that will become part of the individualized transition plan.

E. Health Status Indicators

Introduction

Following each health status indicator us a brief narrative either providing information on the indicator or referring a other sections within the document. Data and data sources are on the forms.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.0	9.4	9.6	9.4	9.2
Numerator	7189	7652	8100	8162	7834
Denominator	79590	81454	84277	86558	85443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data source is the 2008 Provisional Birth files (Tennessee resident only).

Notes - 2007

Data source is Tennessee Birthmaster files resident only

Notes - 2006

Data source is Tennessee Birthmaster files resident only

Narrative:

There has been little change to this indicator over time, although the actual numbers are increasing due to an increase in total births. See NPMs 8, 15, 17, and 18, and SPMs 5 and 6 for information on strategies and activities.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.3	7.6	7.6	7.5	7.1
Numerator	5602	5968	6446	6452	6078
Denominator	76335	78656	84277	86558	85443
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Birth files (Tennessee Resident).

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Notes - 2006
Data source is Tennessee Birthmaster files resident only

Narrative:
There has been little change to this indicator over time, although the actual numbers are increasing due to an increase in total births. See NPMs 8, 15, 17, and 18, and SPMs 5 and 6 for information on strategies and activities.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.7	1.7	1.8	1.7	1.6
Numerator	1343	1354	1508	1513	1379
Denominator	79590	81454	84277	86558	85443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Birth files (Tennessee Resident).

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Notes - 2006
Data source is Tennessee birth master files resident only

Narrative:
There has been little change to this indicator over time. See national performance measure 17 for information on strategies and activities.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.1	1.3	1.4	1.3	1.2
Numerator	827	1029	1166	1159	1045
Denominator	76335	78656	84277	86558	85443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Birth files (Tennessee Resident).

Notes - 2007
Data source is Tennessee Birthmaster files resident only

Notes - 2006
Data source is Tennessee Birth master files resident only

Narrative:
There has been little change to this indicator over time, although the actual numbers have increased due to the increase in total births. See national performance measure 17 for information on strategies and activities.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	12.4	12.6	7.0	8.0	7.2
Numerator	148	150	85	96	86
Denominator	1196148	1188005	1210629	1194718	1201099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Death files (Tennessee Resident).
2008 Population estimates.

Notes - 2007
Data source is Tennessee Health statistics Death file resident only and population estimates.

Notes - 2006

Data source is Tennessee Health statistics Death file resident only and population estimates.

Narrative:
Both the number of deaths and the rates have been decreasing over the past few years. Injury prevention and safety are key components of many programs and services for families with young children. Examples of programs and laws aimed at reducing unintentional injury include home visiting programs; requiring pediatric equipment in emergency response vehicles; grandparent safety education as part of the Older Adult Safety Instructional Series; state laws requiring seat belts, child safety seats, helmets while riding bicycles; prohibiting the transport of children under 12 in truck beds; fines for leaving a child unattended in a motor vehicle; and provision of child safety seats through the Child Safety Fund.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.8	5.0	2.7	3.3	3.0
Numerator	57	59	33	39	36
Denominator	1196148	1188005	1210629	1194718	1201099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Death files (Tennessee Resident).
2008 Population estimates.

Notes - 2007
Data source is Tennessee Health statistics Death file resident only and population estimates

Notes - 2006
Data source is Tennessee Health statistics death files resident only and population estimates

Narrative:
See National Performance Measure 10.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	41.1	45.6	20.9	30.8	25.4
Numerator	332	372	172	257	213
Denominator	808140	815796	821651	833229	839914

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data source is the 2008 Provisional Death files (Tennessee Resident).
2008 Population estimates.

Notes - 2007
Data source is Tennessee Health Statistics Death file resident only and population estimates

Notes - 2006
Data source is Tennessee Health Statistic (Death Files) resident only and population estimates

Narrative:
The death rate for motor vehicle crashes among youth 15-24 has been decreasing over the past five years. The Governor's Office of Highway Safety is responsible for educational activities related to accidents (see NPM 10) for all ages. The Governor recently signed legislation prohibiting sending or reading a text message while driving. A new 90 second video for State employees has just been released by the Division of Risk Management of the Treasury Department, titled "Distracted Driving", which illustrates the danger involved in using cell phone or PDAs while driving.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	13,209.1	13,350.1	13,135.9	13,239.4	13,239.4
Numerator	158000	158600	158253	158173	158173
Denominator	1196148	1188005	1204737	1194718	1194718
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data is estimated from the 2007 Hospital Discharge data.
Numerator Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and Denominator is 2007 population estimates.

Notes - 2007
Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and 2007 population estimates.

Notes - 2006
Data source is Hospital Discharge Tennessee resident only and population estimates

Narrative:
See information in #03A above.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	733.4	723.2	797.2	819.3	819.3
Numerator	8772	8650	9604	9788	9788
Denominator	1196148	1196148	1204737	1194718	1194718
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data is estimated from the 2007 Hospital Discharged.
Numerator Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and Denominator source is 2007 population estimates.

Notes - 2007
Numerator Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and Denominator source is 2007 population estimates.

Notes - 2006
Data source is Hospital Discharge Tennessee resident only and population estimates

Narrative:
See information in #03 A, #03B and #03C above.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4,033.0	4,033.1	3,461.5	3,472.0	3,472.0
Numerator	32592	32625	28239	28930	28930
Denominator	808140	808940	815796	833229	833229
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data is estimated from the 2007 Hospital Discharged data.
Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and 2007 population estimates.

Notes - 2007
Data source is Hospital Discharge Tennessee resident only.
Data source is 2007 Hospital Discharge, Tennessee resident only (Input and Output) and 2007 population estimates.

Notes - 2006
data source is Hospital discharge final inpatients (TN residents only)

Narrative:
See information in #03A, #03B and #03C above.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.2	33.2	36.5	40.0	40.6
Numerator	6594	6648	7373	8153	8422
Denominator	198363	200015	201861	203767	207373
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system and the 2008 Population estimates.

Notes - 2007
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system.
and the 2007 Population estimates.

Notes - 2006
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system.

Narrative:

The number of cases of chlamydia reported in ages 15-19 continues to increase primarily due to expanded screening in this population. See SPM 5 for information on activities and strategies.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.6	8.7	10.1	10.4	11.0
Numerator	9035	9092	10539	10859	11468
Denominator	1047782	1046385	1043888	1041926	1045545
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system and the 2008 Population estimates.

Notes - 2007
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system and the 2007 Population estimates.

Notes - 2006
Data source is the state STD program surveillance which is the Communicable Disease Surveillance system.

Narrative:
The number of cases of chlamydia reported in ages 20-44 continues to increase primarily due to expanded screening in the state. Screening for chlamydia is a HEDIS measure for the managed care organizations participating in the TennCare/Medicaid program. All health department clinics (in all counties) offer chlamydia screening to women under age 30 requesting a pregnancy test. Other information is in SPM 5.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80470	60727	17857	0	0	0	0	1886
Children 1 through 4	322836	244687	70459	0	0	0	0	7690
Children 5	395254	299944	86320	0	0	0	0	8990

through 9								
Children 10 through 14	402449	306505	88006	0	0	0	0	7938
Children 15 through 19	426040	330783	87991	0	0	0	0	7266
Children 20 through 24	413874	325541	79594	0	0	0	0	8739
Children 0 through 24	2040923	1568187	430227	0	0	0	0	42509

Notes - 2010
Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Narrative:
Information addressing services for children is contained within the main narrative of this application. Changing demographics is addressed in the overview section.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	76515	3955	0
Children 1 through 4	305542	17294	0
Children 5 through 9	374681	20573	0
Children 10 through 14	385870	16579	0
Children 15 through 19	410978	15062	0
Children 20 through 24	396030	17844	0
Children 0 through 24	1949616	91307	0

Notes - 2010
Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

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Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Data source is the 2008 population estimate.

Narrative:
The Hispanic population continues to increase in Tennessee. Information on services targeting this population is contained in numerous sections of this application.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	150	51	82	0	0	0	0	17
Women 15 through 17	3327	1714	1212	0	0	0	0	401
Women 18 through 19	7809	4771	2372	0	0	0	0	666
Women 20 through 34	65436	44971	13154	0	0	0	0	7311
Women 35 or older	8610	6289	1281	0	0	0	0	1040
Women of all ages	85332	57796	18101	0	0	0	0	9435

Notes - 2010
Women of all ages includes those records with age unknown.
Data source is the State of Tennessee provisional birth master files (Tennessee residents only).

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Women of all ages includes those records with age unknown.
Data source is the State of Tennessee provisional birth master files (Tennessee residents only).

Narrative:
The overall number of births continues to increase. Narrative sections of the application address services for pregnant women and infants.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	128	22	0
Women 15 through 17	2943	384	0
Women 18 through 19	7158	651	0
Women 20 through 34	59183	6253	0
Women 35 or older	7892	718	0
Women of all ages	77304	8028	0

Notes - 2010
Women of all ages includes those records with age unknown.
Data source is the State of Tennessee provisional birth master files (Tennessee residents only).

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Women of all ages includes those records with age unknown.
Data source is the State of Tennessee provisional birth master files (Tennessee residents only).

Narrative:
The number of live births to Hispanic women continues to increase. Health department clinics have been addressing the needs of this population (i.e., language and culture) for many years.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	683	395	273	0	0	0	0	15
Children 1 through 4	117	71	43	0	0	0	0	3
Children 5 through 9	55	33	21	0	0	0	0	1
Children 10 through 14	69	48	21	0	0	0	0	0
Children 15 through 19	290	205	79	0	0	0	0	6
Children 20	451	335	109	0	0	0	0	7

through 24								
Children 0 through 24	1665	1087	546	0	0	0	0	32

Notes - 2010
Data source is 2008 Death files (Tennessee residents only)
Ages less than 1 year only.

Data source is 2008 Death files (Tennessee residents only)

Data source is 2008 Death files (Tennessee residents only)

Data source is 2008 Death files (Tennessee residents only)

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Data source is 2008 Death files (Tennessee residents only)

Narrative:
Tennessee's Child Death Review teams, which are located in all judicial districts across the state, review all deaths to children and make recommendations to the State for legislation and systems changes. Four pilot projects are being implemented to establish teams to review fetal and infant deaths in three large metropolitan counties and one rural region in East Tennessee. Both systems are designed to change systems at the community level and to recommend policy changes.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	630	53	0
Children 1 through 4	108	9	0
Children 5 through 9	52	3	0
Children 10 through 14	67	2	0
Children 15 through 19	280	10	0
Children 20 through 24	412	39	0
Children 0 through 24	1549	116	0

Notes - 2010
Data source is 2008 Death files (Tennessee residents only)
Ages less than 1 year only.

Data source is 2008 Death files (Tennessee residents only)

Data source is 2008 Death files (Tennessee residents only)

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Narrative:
Tennessee's Child Death Review teams, which are located in all judicial districts across the state, review all deaths to children and make recommendations to the State for legislation and systems changes. Four pilot projects are being implemented to establish teams to review fetal and infant deaths in three large metropolitan counties and one rural region in East Tennessee. Both systems are designed to change systems at the community level and to recommend new laws.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1627049	1242646	350633	0	0	0	0	33770	2008
Percent in household headed by single parent	33.0	0.0	0.0	0.0	0.0	0.0	0.0	33.0	2008
Percent in TANF (Grant) families	8.7	35.9	63.4	0.0	0.5	0.0	0.1	0.0	2008
Number enrolled in Medicaid	816486	0	0	0	0	0	0	816486	2008
Number enrolled in SCHIP		0	0	0	0	0	0	0	2008
Number living in foster home care	11366	8586	2463	25	16	9	260	7	2008
Number enrolled in food stamp program	430096	259550	165505	744	2922	342	1033	0	2008
Number enrolled in WIC	325805	189790	88759	82	1897	0	0	45277	2008
Rate (per 100,000) of juvenile crime arrests	91.0	0.0	0.0	0.0	0.0	0.0	0.0	91.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.1	41.9	54.8	0.1	0.5	0.1	0.0	0.1	2008

Notes - 2010
Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is Tenncare data report. Data are not currently categorized by race.

No data available, SCHIP included in total TennCare.

Data source is the State of Tennessee Food Stamp program.

Data source is the State of Tennessee WIC program.

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data). 1419 detained and committed youth in custody in year 2006 according to KIDS count data and at a rate of 91/100,000 youth.

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data).

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data).

Narrative:
Tennessee has many persons living at or near poverty as reflected by the information on infants and children enrolled in the various programs and services.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1553586	73463	0	2008
Percent in household headed by single parent	0.0	0.0	0.3	2008
Percent in TANF (Grant) families	98.1	1.9	0.0	2008
Number enrolled in Medicaid	0	0	816486	2008
Number enrolled in SCHIP	0	0	0	2008
Number living in foster home care	10681	431	254	2008
Number enrolled in food stamp program	404987	25110	0	2008
Number enrolled in WIC	208528	45277	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	91.0	2008
Percentage of high school drop-outs (grade 9 through 12)	97.4	2.6	0.0	2008

Notes - 2010
Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is Tenncare data report.

No data available since the State of Tennessee does not have a seperate SCHIP program.

Data source is the State of Tennessee Food Stamp program.

Data source is the State of Tennessee WIC program.

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data). 1419 detained and committed youth in custody in year 2006 according to kids count data and at a rate of 91/100,000 youth.

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data).

Data source is the state of Tennessee statewide report card (2008 KIDS Count Data).

Narrative:
Tennessee has many persons living at or near poverty as reflected by the information on infants and children enrolled in the various programs and services.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	1039089
Living in rural areas	587960
Living in frontier areas	0
Total - all children 0 through 19	1627049

Notes - 2010
Data source is the 2008 population estimate.
Tennessee classifies demographic areas in two categories namely rural and urban areas.
State data and U.S. census data source.

Data source is the 2008 population estimate.
Tennessee classifies demographic areas in two categories namely rural and urban areas.
State data and U.S. census data source.

Data source is the 2008 population estimate.
Tennessee classifies demographic areas in two categories namely rural and urban areas.
State data and U.S. census data source.

Data source is the 2008 population estimate.
Tennessee classifies demographic areas in two categories namely rural and urban areas.
State data and U.S. census data source.

Narrative:
The majority of Tennessee's children live in urban settings, although there are still 36% living in the rural areas of the state.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6144738.0
Percent Below: 50% of poverty	6.1
100% of poverty	14.5
200% of poverty	34.5

Notes - 2010
Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Narrative:
Over 34% of Tennessee's population is below 200% of the federal poverty level. Children and families are in great need of public health and social services in the state. However, shrinking state resources are making it more difficult to be able to provide the services requested and needed.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1627049.0
Percent Below: 50% of poverty	8.0
100% of poverty	17.6
200% of poverty	41.0

Notes - 2010
State data and U.S. census data source.
Data source is the 2008 population estimate.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Data source is the 2008 population estimate.
State data and U.S. census data source.

Narrative:
A higher percentage of children than the overall population is at below all three poverty levels (50, 100, and 200). Children are living in situations where they are in greater need of services than the overall population.

F. Other Program Activities

The MCH section operates two hotlines. Both are staffed by the MCH and Women's Health sections. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. Patient information is provided to TennCare high risk pregnant women. Over 40 health education materials are available for distribution.
The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.
MCH has four mandated advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee. Other task forces and advisory groups for MCH programs (not mandated by law) include: Tennessee Childhood Lead Poisoning Prevention Advisory Committee, Adolescent Health Advisory Committee, Asthma Task Force, and Early Childhood Comprehensive Systems Work Group.
Quality Management System: The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Directors of MCH and Women's Health/Genetics serve on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week of every year in all rural clinics.

G. Technical Assistance

We anticipate request of Technical Assistance as our Needs Assessment indicates. At this time two items for technical assistance are listed on Form 15: (1) How to integrate programs which have categorical funding streams and have historically worked as categorical, separate programs; and (2) Mentoring for the Director of the Children and Youth with Special Health Care Needs Program.

V. Budget Narrative

A. Expenditures

The Bureau of Administrative Services (BAS) within the Department of Health is responsible for all fiscal management. BAS uses the State of Tennessee's Accounting and Reporting system (STARS) for budgeting, collection of revenues and distribution of expenditures by allotment code and program cost center. Computer generated cumulative expenditure and receipt plan analysis, transaction listings and spending receipt plan is available statewide on-line for all MCH programs and can be accessed by both central and regional office staff. Financial audits are the responsibility of the Comptroller's Office. All departments, offices and programs within state government are subject to frequent audits. Contract agencies are also audited frequently. MCH program staff provide site visits and program monitoring at contract agencies in order to assure compliance with the contract's scope of services. Fiscal monitoring of contract agencies is the responsibility of the Department of Health's Internal Audit staff.
Maternal and Child Health Programs are organizationally aligned to the Bureau of Health Services, Tennessee Department of Health. The Bureau of Health Services has developed detailed policies and procedures for use by local health departments, metropolitan health departments, regional public health offices and central office staff involved with budgeting of funds, collection of revenues, depositing revenues, accounts receivable, aging of accounts, charging patients and third parties, petty cash, posting receipts and contracting for services. Bureau of Health Services policies and procedures are available to all sites and are posted on the Department's Intra-Net for easy references. All policies and procedures have been developed in accordance with applicable state law and rules of the Department of Finance and Administration.

B. Budget

Tennessee state law requires all departments to submit a complete financial plan and base budget request for the ensuing fiscal year that outlines proposed expenditures for the administration, operation and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Bureau of Health Services Fiscal Services Section, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each program.

The Department of Health uses a cost allocation system for local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Bureau of Health Services central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patient care services delivered in rural health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for the Tennessee Department of Health. RBRVS is fully automated with computer linkage at the service delivery level to AS 400 computers at the regional and central offices.

Program encounter data are entered at local health departments for direct patient care services using CPT procedure and program codes. Relative value units assigned to each procedure code allow a proportionate amount of cost to be associated with each procedure. RBRVS provides monthly cost allocation reports to central and regional office staff. These reports are used to monitor expenditures, determine cost for services provided, and allocate resources as needed.

The maintenance of effort for the Maternal and Child Health Block Grant was established in 1989 in accordance with requirements of the block grant. The maintenance of effort, $13,125,024.28, was established through an analysis of 15 months of expenditures for Maternal and Child Health Programs, adjusted for differences between the state and federal fiscal years, as well as adjustments for accrued liabilities. The Tennessee Department of Health and the Bureau of Health Services fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeting, maintenance and match requirements set forth in the block grant regulations. Any carry forward noted in the annual report will be used to support or expand Maternal and Child Health activities. Carry forward funding has been used to develop new services or to expand current programs. During these recent years carry forward funding has been used to improve dental and other health care screening services, provide preventive fluoride varnish for children seen in health department clinics, funded increased program activity relative to infant mortality, teen pregnancy prevention and enhance breast and cervical screening for reproductive age women. Funding was also used to increase home visiting services for pregnant women and families with high risk infants and young children and care coordination services for families with children with special health care needs.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.